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Canada. Royal commission on health services.
Hearings, v. 24-26. 1962.

1964

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

EDMONTON

ALTA.

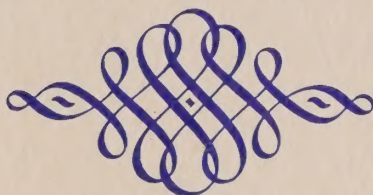
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5483 DIRECTOR OF RESEARCH

5484 PROF. BERNARD BLISSEN

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held in Edmonton, Alberta,
14th day of February, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL -- Chairman
MISS ALICE GIRARD, R.N.
DR. DAVID M. BALTZAN
PROF. O.J. FIRESTONE
MR. M. WALLACE McCUTCHEON, Q.C.
DR. C.L. STRACHAN
DR. ARTHUR F. VAN WART

COMMISSION COUNSEL

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE



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PMcH/dpw

Edmonton, Alberta,
Wednesday, February
14th, 1962.

--- On commencing at 9 a.m.

THE CHAIRMAN: The submission of The
Alberta Dental Association will be Exhibit 119 and the
post-payment plan adenda will be Exhibit 119A.

--- EXHIBIT NO. 119: Submission of The Alberta Dental
Association.

--- EXHIBIT NO. 119A: Post-payment plan.

SUBMISSION OF THE ALBERTA DENTAL ASSOCIATION

Appearances: Dr. M.M. Woronuk, President
Dr. L.K. Brooks, Past President
Dr. J. Zimmerman
Dr. J.E. Young, Vice President
Dr. C.W.B. McPhail
Dr. R.A. Rasmussen
Dr. H.R. MacLean
Dr. G.E. Decker, Secretary-
Registrar
Mr. J.P. Furnell

DR. WORONUK: Mr. Chairman, for the
presentation of our brief, Dr. Brooks will be doing the
presenting and if it is your pleasure we can commence
our presentation by asking him to take over at this
time.

THE CHAIRMAN: Yes, Dr. Brooks?

DR. BROOKS: The Alberta Dental Association, in this submission, presents an outline of present
dental facilities and recommendations for their improve-
ment under the four headings of: (1) Dental Education,
(2) Prevention, (3) Treatment Services, (4) Research.

Both favorable and unfavorable aspects
exist. Some of the favorable aspects are:

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(a) A dentist to population ratio that is the third best of all the provinces.

(b) Excellent facilities for the training and graduating of 50 dentists per year in the Faculty of Dentistry, University of Alberta.

(c) A newly instituted two-year university course of training for dental auxiliaries (Alberta). This course allows for the extension and expansion of dental auxiliary services.

(d) Recent legislation which gives recognition to and provides for the standardization and upgrading of dental laboratory technical services. (The Dental Technicians' Act).

(e) A well organized Pensioners' Treatment Service program to provide dental care to welfare recipients and their dependents.

(f) Gradually expanding preventive dental health programs, throughout the province, in health units and city health departments.

(g) A volunteer program of supplying dental services for outlying areas of the province.

(h) Most of the plebiscites on fluoridation held in the province have obtained more than a straight majority favorable vote, showing that the public desires fluoridation of communal water supplies.

Some of the unfavorable aspects are:

(a) The lack of information relating to the needs and demands for dental services of the whole population.

(b) The inequitable distribution of



(a) A dentist to population ratio

that is the third best of all the provinces.

(b) Excellent facilities for the

training and graduating of 50 dentists per year in the

Faculty of Dentistry, University of Alberta.

(c) A newly instituted two-year unive

This course allows for the extension and expansion of

mental auxiliary services.

(d) Recent legislation which gives

recognition to and provides for the standardization and

upgrading of dental laboratory technical services. (f)

Dental Technicians' Act.

(e) A well organized Dental-Work Treat-

ment Service program to provide dental care to welfare

residents and their dependents.

(f) Gradually expanding preventive

dental health programs, throughout the province, in

health units and city health departments.

(g) A volunteer program of supplying

dental services for outlying areas of the province.

(h) Most of the physicians on financial

tion held in the province have obtained more than a

majority favorable vote, showing that the public

desires fluoridation of communal water supplies.

(i) The dental profession is still

on the whole

population.

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3 dental services between urban and rural centres.

4 (c) The lag between scientific findings
5 and public acceptance of proven measures of prevention
6 and control of dental disease.

7 (d) The misleading and unreasoning
8 propaganda directed against the proven public health
9 measure of fluoridation of communal water supplies.

10 (e) Legislation which requires a two-
11 thirds favorable vote in fluoridation plebiscites before
12 fluoridation can be instituted.

13 (f) Legislation, such as The Certified
14 Dental Mechanics' Act of Alberta (1961), which permits
15 persons, with no formal training in the background
16 sciences related to dental health, to provide full den-
17 tures directly to the public.

18 Following are the major recommendations
19 submitted to the Royal Commission on Health Services:

20 1. Dental Education

21 i. That the position of Director of
22 Dental-Public Health be made a full time appointment.

23 ii. That more rigid control be exer-
24 cised over commercial advertising relating to dental
25 health.

26 iii. That dental health teaching be
27 included in all schools at all grade levels.

28 iv. That the use of radio, newspaper
29 and television for dental health education be increased.

30 v. That volunteer organizations
promoting dental health be encouraged and assisted.



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2. Prevention

i. That all communal water supplies, deficient in fluoride, be brought up to the optimum fluoride concentration.

ii. That factual information specifically related to fluoridation be made available from all levels of government.

3. Treatment Services

i. That the Pensioners' Treatment Service program, administered by the Alberta Dental Association on behalf of the Provincial Government, be expanded gradually to include all social welfare dental care.

ii. That further investigation, development and promotion of prepaid and post-paid plans for dental health be undertaken under the direction and guidance of the dental profession.

iii. That dental auxiliaries be made available to dentists in private practice at the earliest practical date to supplement their preventive and treatment services.

iv. That a standard and comprehensive training course for dental assistants be provided by a vocational school.

v. That a critical view of the existing program of scholarships, awards, grants and low interest loans to high school and under-graduate students be undertaken.

vi. That the recruitment program be expanded, with emphasis on students from rural areas and



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3 female students.

4 vii. That there be a greater number
5 of dental appointments to hospital staffs.

6 viii. That beds be made available for
7 patients requiring dental treatment, with particular
8 regard to patients forced to travel great distances.

9 ix. That active treatment and large
10 chronic hospitals provide facilities for general dental
11 care

12 x. That all dental health services
13 be provided under the supervision or direction of a
14 fully qualified dentist who shall assume full responsi-
15 bility and that all legislation comply with this prin-
16 ciple.

17 4. Research

18 i. That research in basic and
19 applied science and the humanities related to dental
20 health be promoted and financially supported by all
21 governments.

22 ii. That provincial governments
23 implement studies to determine the needs and the actual
24 demands for dental health services of the provinces'
25 total populations.

26 iii. That dentists be encouraged to
27 combine the career of research and teaching by providing
28 the incentives of adequate facilities and remuneration.

29 THE CHAIRMAN: Thank you very much,
30 Dr. Brooks. Dr. Strachan, have you some questions?

COMMISSIONER STRACHAN: I notice,
gentlemen, that you have placed considerable emphasis



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3 on dental health education in your brief. We realize
4 this is an important factor. You also recommend the
5 rigid control over commercial advertising; how would
6 you advise doing that?

7 DR. BROOKS: We would suggest that more
8 teeth be placed in the Food and Drug Act.

9 COMMISSIONER STRACHAN: In what respect?

10 DR. BROOKS: So that misleading and
11 inferential statements could be more rigidly controlled.
12 We feel that people are given a false sense of security
13 by some commercial advertising that although the adver-
14 tising in scientific fact could not be faulted, the
15 inferences behind their statements and the way they are
16 phrased do mislead our patients to the detriment of their
own health.

17 COMMISSIONER STRACHAN: That covers
18 advertising but what about dental health education? How
19 would you accomplish the suggestions you have made?

20 DR. BROOKS: By actively promoting or
21 having co-operation from the Provincial Government in
22 actively promoting the dental health care programs in
23 the schools and in our various media. We have no media
to speak of at the moment at all.

24 COMMISSIONER STRACHAN: Well, to come
25 to this more specifically, do you consider it a profes-
sional or governmental responsibility?

26 DR. BROOKS: We feel in the office it
27 is a professional responsibility and that education in
28 the preventive service is a government responsibility,
29 the treatment service being the professional responsibility
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4 COMMISSIONER STRACHAN: In your presen-
5 tation you have definitely stressed the fluoridation of
6 communal water supplies as the most effective preventive
7 measure. What efforts have the profession made in this
8 province towards communal water fluoridation?

9 DR. BROOKS: We made tremendous
10 efforts at the sacrifice of literally hundreds of hours
11 of office time, not to mention the hours in the evenings.
12 We are the only ones that did promote fluoridation.
13 Initially we organized lay groups and educated lay groups,
14 acting as technical advisors for them. We financed
15 some lay groups, gave financial assistance as individuals
16 and as an Association. We carried on a most extensive
17 campaign in the press with their co-operation and on
18 radio and TV. We attempted to get to every home and
19 school association, service club, women's organization,
20 church group, that we could in any area where we could
21 ask for a referendum to be held on fluoridation.

22 We made presentations to the Provincial
23 Government regarding fluoridation; we made presentations
24 to civic and municipal governments. Also, I think at
25 one time we had a library of hundreds of books and
26 research articles on fluoridation and most of it has
27 been donated either to the University or the Calgary
28 General Hospital.

29 Literally, without being complimentary
30 to our own group, you could say there was nothing we
left undone in the promotion of fluoridation.

31 COMMISSIONER STRACHAN: And I take it
32 you made representations to the Government to overcome



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3 the two-thirds majority necessary?

4 DR. BROOKS: Repeatedly.

5 COMMISSIONER STRACHAN: Without good
6 reception?

7 THE CHAIRMAN: What is the real block?
8 What is the real obstacle to actually convincing the
9 public more or less generally about the benefits of
10 fluoridation?

11 DR. BROOKS: Well, sir, we do not know
12 but we think it is history repeating itself, that people
13 are afraid of something new. Where you have people who
14 cannot be readily identified scaring people who are in
15 no position to know what a fluoride ion is and have some
16 reputedly responsible person who tells them if they take
17 this fluoride if they are pregnant they will abort, if
18 they are a certain age you will go bald-headed and if
19 you are something else you will get cancer. We have had
20 all these things thrown out and it has frightened people.
21 This has frightened enough people that we find it diffi-
22 cult to get a two-thirds majority in our vote to have
23 fluoridation.

24 THE CHAIRMAN: The same philosophy that
25 made it difficult to modernize the homes in England?

26 DR. BROOKS: The same thing with x-rays,
27 the House of Lords argument there to prevent the use of
28 x-rays because you would see through clothing. The same
29 thing happened with the treatment of vaccine but they
30 did not have a 66 and two-thirds referendum either.

THE CHAIRMAN: What percentage of the
votes in the votes that you refer to under paragraph H

What is the real block?

What is the real obstacle to actually contacting the public more or less generally about the benefits of

DR. BLOCKS: Well, sir, we do not know

but we think it is history repeating itself, that people are afraid of something new. Where you have people who cannot be readily identified as being people who are in no position to know what a fluoride is and have some responsibility. A person who tells them if they take this fluoride if they are pregnant they will abort, if they are a certain age you will go bald-headed and if you are something else you will get cancer. We have had all these things thrown out and it has frightened people. This has frightened enough people that we find it difficult to get a two-thirds majority in our vote to have fluoridation.

THE CHAIRMAN: The same philosophy the

made it difficult to modernize the houses in England?

the house of lords argument there to prevent the use of x-rays because you would see through clothing. The same thing happened with the treatment of vaccine but they did not have a 66 and two-thirds referendum either.

THE CHAIRMAN: What percentage of the



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3 on page 1 - must have obtained more than a straight
4 majority?

5 DR. McPHAIL: To date 20 out of 29
6 plebiscites held under this legislation have obtained
7 over a straight 50%; 15 have obtained over 60% and 13
8 have obtained over the necessary two-thirds.

9 THE CHAIRMAN: How many under 50?

10 DR. McPHAIL: That would be 9 out of
11 29 under 50. In the instance of the City of Edmonton
12 its second plebiscite in 1959 or 1957 was just 1 or 2%
13 under the necessary two-thirds.

14 THE CHAIRMAN: Is it difficult to get
15 a plebiscite under way? Is it a matter of getting a
16 petition or how do you originate a vote?

17 DR. McPHAIL: It is a matter of approaching
18 the municipal council or city council to have them put
19 forth a plebiscite which must be publicized, published
20 and then held. If a vote fails there must be a two-year
21 lapse of time before another plebiscite can be held.

22 COMMISSIONER McCUTCHEON: Supposing the
23 vote is successful and fluoridation is instituted, can
24 you have a plebiscite to remove it?

25 DR. McPHAIL: Yes, by the institution
26 of two-thirds vote rescinding the legislation.

27 THE CHAIRMAN: And the same two-year
28 lapse?

29 DR. McPHAIL: I do not know if there
30 is any reference to that, I do not recall any reference
that there must be a lapse.

DR. BROOKS: I think so.



DR. McHALL: To date 20 out of 29

plebiscites held under this legislation have obtained over a straight 50%; 15 have obtained over 50% and 13 have obtained over the necessary two-thirds.

DR. McHALL: That would be 3 out of

23 under 50%. In the instance of the City of Houston its second plebiscite in 1959 or 1960 was just 1 or 2% under the necessary two-thirds.

THE CHAIRMAN: Is it difficult to get

a plebiscite under way? Is it a matter of getting a

petition or how do you originate a vote?

DR. McHALL: It is a matter of getting

the municipal council or city council to have them put forth a plebiscite which must be published, published and then held. If a vote falls there must be a two-year time before another plebiscite can be held.

COMMISSIONER McOUTERSON: Supposing

vote is successful and then a plebiscite is instituted, can you have a plebiscite to remove it?

DR. McHALL: Yes, by the institution

of two-thirds vote rescinding the legislation.

Pages?

DR. McHALL: I do not know if there

is any reference to that, I do not recall any reference that there must be a lapse.



B/PB/dpw

1 COMMISSIONER STRACHAN: With reference to the dental
2 health programs you state 16 of the 24 health units in
3 Alberta operated dental health programs in 1961. Does
4 that mean there were sixteen dentists employed in these
5 health units? DR. BROOKS: If I might have Dr. Young
6 answer that.

7 DR. YOUNG: I think perhaps Dr. McPhail
8 would be better.

9 DR. McPHAIL: Of those, six had a
10 full-time dental officer, one a half-time dental officer,
11 two had the services of a dentist on a part-time basis
12 for a period of four to six months and the others had
13 the services of a third-year dental student during the
14 summer recess period.

15 COMMISSIONER STRACHAN: How many quali-
16 fied dental health officers with D.D.P.H. degrees are
17 there in the province?

18 DR. McPHAIL: Four; one in private prac-
19 tice and three in public health services.

20 COMMISSIONER STRACHAN: None employed
21 full-time?

22 DR. McPHAIL: Three on a full-time
23 health service.

24 COMMISSIONER STRACHAN: Where are they
25 employed?

26 DR. McPHAIL: One is the Jasper Place
27 health unit, one in the City of Edmonton and one in the
28 City of Calgary.

29 COMMISSIONER STRACHAN: How can you
30 hope to carry out a dental health program without quali-
fied dentists?

DR. McPHAIL: We hope that the dentist
in public health will eventually consider taking public



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3 health training. However, in discussing it with these,
4 one of the problems, of course, is the fact that the
5 remuneration, the professional training grant for a
6 married man is \$250 a month. A man with a family hesi-
7 tates sometimes to set out and take this training with
8 this financial loss he would have to undergo. In some
9 areas there is a supplement to this by the supporting
10 health unit or by the supporting government.

11 THE CHAIRMAN: For how many months
12 would this operate?

13 DR. McPHAIL: This would be a period
14 of approximately nine months, nine to ten months.

15 THE CHAIRMAN: It is one year?

16 DR. McPHAIL: One-year course, sir.

17 COMMISSIONER STRACHAN: The four with
18 the D.D.P.H. degree, have they had the professional
19 training grants?

20 DR. McPHAIL: I believe three did and the
21 other one took it under his own finances.

22 COMMISSIONER STRACHAN: Referring to
23 page 8, paragraph 18, where you speak of the distribution
24 of dentists in the Province of Alberta in the dental
25 service development in rural areas and you say you have
26 made considerable effort to solve it, to alleviate the
27 situation. In your opinion what is the answer to this?

28 DR. BROOKS: The answer is supply and
29 demand, sir. In many areas, although the area does
30 want a dental officer they couldn't support one. We
have had examples in Alberta of where, because of the
good transportation facilities, patients will come 100



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3 miles, where they have a dentist in their community, a
4 well-qualified man, come into town to see me. I have
5 said, "If you don't support your dentist he will have
6 to leave". They haven't supported him and that dentist
7 from that particular small community has moved to the
8 city and is doing well, and is possibly serving more
9 country patients than he did in the country. It is
10 supply and demand. If there is any demand in the
11 country that would support a dentist there would be one
12 there.

13 The other partial answer to this, you
14 asked what the other answer would be, we have this
15 voluntary dental health program where we have dentists
16 in mobile clinics serving areas that request it. Dr.
17 Young is the Chairman of this Committee. Would you
18 like to hear him?

19 DR. YOUNG: This is something we do
20 together with the Department of Health, in conjunction
21 with the Department of Health. The dentists on a volun-
22 tary basis in the very outlying areas go for a one or
23 two-week period, depending on the need. To date we
24 have been very successful in serving seven or eight of
25 these areas in the province. The service has worked
26 out extremely well for the citizens concerned and the
27 dentists realizing their moral obligation are quite
28 content.

29 DR. BROOKS: However it is rather
30 interesting from a social standpoint some areas that
have complained and wanted a dentist haven't requested
this service.



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4 THE CHAIRMAN: Gentlemen, I am going
5 to ask everyone, including Dr. Strachan, if you would
6 speak up. The acoustics are poor. While we can hear
7 you there are others in the room who can't and they
8 are entitled to hear what is going on.

9 COMMISSIONER STRACHAN: I am sure you
10 would expect me to ask something about the social service
11 program. As you state on page 10 it commenced in 1947
12 and is, no doubt, one of the earliest ones in Canada.
13 On what basis are the dentists paid for their service?

14 DR. BROOKS: Between 30 and 50% less
15 than the normal fee charged, depending on the type of
16 service and the particular office involved.

17 THE CHAIRMAN: To whom is that service
18 rendered, social service program, to how many people,
19 what portion of the population, percentage-wise?

20 DR. DECKER: Approximately 50,000 people,
21 sir, the same group that the medical people do.

22 THE CHAIRMAN: You have an agreement
23 with the Provincial Government?

24 DR. DECKER: Yes, sir.

25 THE CHAIRMAN: With some department
26 of government?

27 DR. DECKER: The Department of Health,
28 sir.

29 THE CHAIRMAN: By which you receive
30 payment on a percentage of the normal tariff?

DR. DECKER: No, we get a grant per
person per month, 40%.

THE CHAIRMAN: How does it work out?



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3 Can you translate it to the amount you get for your
4 service in relation to what you would get on the ordi-
5 nary patient?

6 DR. DECKER: About 50% lower than the
7 usual fee charged on a private basis.

8 THE CHAIRMAN: Your dental profession
9 is subsidizing the social service work for the province
10 to that extent?

11 DR. DECKER: To a degree, yes.

12 COMMISSIONER McCUTCHEON: Are these
13 monies pro-rated amongst the dentists who give care to
14 the group?

15 DR. McPHAIL: At the present time we
16 have a special fee schedule set up. We are contemplating
17 changing it to pro-rated.

18 COMMISSIONER McCUTCHEON: Supposing
19 you get so much per month per patient, supposing they
20 come and wanted dental treatments. It wouldn't take
21 care of the expense.

22 DR. DECKER: We are looking after about
23 20%.

24 COMMISSIONER McCUTCHEON: The other
25 80% don't care whether they have to go to the dentist
26 or not even if the treatment is free?

27 DR. DECKER: That is right.

28 COMMISSIONER McCUTCHEON: There are a
29 lot of people like that.

30 THE CHAIRMAN: Why does the dental
profession of Alberta work cheaper for the Government
than for the individual? Does the individual have more



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Can you translate it to the group: you get for your service in relation to what you would get on the

is subsidizing the social service work for the group

DR. PARKER: To a degree, yes.

months presented amongst the dentists who give a

have a special fee schedule set up. We are continuing

care of the elderly

don't care whether they have to go to the dentist or not even if the treatment is costly

1 of people like that.

proportion of children were observed for the Government than for the individual? Does the individual have more



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3 money than the Government?

4 DR. BROOKS: It is not for the Government
5 we are working more cheaply. It is for the social
6 assistance group of individuals, the welfare group; and
7 we are pleased to do this type of work for a group who
8 couldn't get dentistry any other way. It is one of our
9 charities.

10 THE CHAIRMAN: Isn't it the Government's
11 obligation to provide the service, the community as a
12 whole, or the State, let us put it that way?

13 DR. BROOKS: I don't know who, at any
14 rate, we are prepared to fulfill what we feel to be our
15 moral obligation to help look after these people and we
16 do, and look after others besides.

17 COMMISSIONER STRACHAN: Why should you
18 do it to such an extent, 30 to 50%? Is this schedule
19 adjusted from time to time?

20 DR. BROOKS: Yes. We have had adjust-
21 ment in fees or in grants from the Government on one or
22 two occasions, but if we didn't do it this way, if we
23 didn't have government assistance we couldn't look after
24 this number of charity cases, let us put it that way.
25 There is a limit at which we would be losing money in
26 our office if we were to do every one of the charity
27 patients. Then, of course, we couldn't live and by the
28 Government assisting we can look after more charity
29 cases.

30 These groups do definitely fall in the
social assistance group.

COMMISSIONER STRACHAN: But the



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3 Government, after all, is only making a contribution
4 toward it.

5 DR. BROOKS: True, and we are also.

6 COMMISSIONER STRACHAN: You certainly
7 are.

8 DR. BROOKS: If the Government didn't
9 make any contribution we would be expected to make the
10 entire contribution and I don't think we could do that
11 much.

12 THE CHAIRMAN: I can understand the
13 Government being satisfied with the arrangement as
14 suggested the other day by the Minister. Do you feel
15 the profession generally is well satisfied?

16 DR. BROOKS: I do, sir, yes. It is not
17 ideal but we are well satisfied with it, yes.

18 THE CHAIRMAN: If that operated all
19 over we could get all the professions to subsidize govern-
20 ment and we could save millions of dollars.

21 DR. BROOKS: These are for the social
22 assistance groups as specifically stated in our Appendix
23 C.

24 THE CHAIRMAN: We know who they are.

25 DR. BROOKS: I am sorry. There is a
26 means test involved for these particular individuals.

27 COMMISSIONER BALTZAN: You consider
28 the patients charity and regard the Government as being
29 indigent?

30 COMMISSIONER STRACHAN: Coming to
another subject, how many dental hygienists are there
in the province?



There are some things which we wish to explain to you in the
order of the day and I think I had better say that

THE first of these is

Government being established, and the first of these
is the order of the day for the first day. In the
first of these, however, it is a matter of

that we are now in a position to

the first of these is

even so, I think it is a matter of
that we are now in a position to

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provision and so on, and I think it is a matter of

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DR. BROOKS: Four.

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COMMISSIONER STRACHAN: Where are they
employed?

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DR. BROOKS: Two in private offices
and two, one for the City of Edmonton and one for the
City of Calgary - one for the University.

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THE CHAIRMAN: If you don't mind, before
we leave this subject, Dr. McPhail, would it be embarrass-
ing to you to pursue this further, why a provincial
government must impose upon the dental profession an
obligation of subsidizing social assistance in Alberta
because you see, we must look at this as an overall
picture all over Canada; are all governments to have
the same philosophy of asking individual groups to
subsidize them in looking after the social aid in the
province?

18

DR. McPHAIL: I couldn't say, sir, just
what the answer to that is.

19

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THE CHAIRMAN: If you buy clothes, if
the Department of Welfare buys clothes for an indigent
family does it expect the haberdasher to contribute 30 to
50% of the cost?

23

DR. McPHAIL: No sir, they wouldn't.

24

THE CHAIRMAN: Or the dentist.

25

COMMISSIONER McCUTCHEON: Or the super-
market.

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27

DR. McPHAIL: This is a professional
obligation, in assisting in this problem.

28

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THE CHAIRMAN: You say that the profes-
sion feels an obligation or that the Government feels

30



Dr. McNeill:

and two, one for the City of Edmonton and one for the

City of Calgary - one for the University.

THE CHAIRMAN: If you don't mind, Dr.

we leave this subject, Dr. McNeill, would it be an error

to ask you to report this further, say a presentation

document that would show the latest situation and

obligation of subsidizing social assistance in Alberta

because you see, we must look at this as an overall

picture all over Canada; and all governments have

the same philosophy of making a financial effort to

reduce the cost of living after the initial effort is

made.

Dr. McNeill: I couldn't say, say, but

what the answer to that is.

THE CHAIRMAN: If you say otherwise, if

the Department of Welfare has a number for an incident

family does it expect to be transferred to another job?

End of the story?

Dr. McNeill: No sir, they wouldn't.

THE CHAIRMAN: Or the contrary.

THE CHAIRMAN: M. G. McNeill: The question

market.

Dr. McNeill: This is a professional

collaboration, in assisting in this process.

THE CHAIRMAN: Is it that the profes-

sion feels an obligation on that the Government feels



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that the profession has an obligation.

DR. McPHAIL: I think it is a mutually agreed problem. As I understand it the profession in the province is satisfied with this now, so I would say it is the profession who feels this obligation as it now exists, they have voluntarily undertaken this problem.

THE CHAIRMAN: Yes, they have voluntarily undertaken and then they claim deficiencies in other areas and want government assistance for education and this and that and the other thing. If they were paid for their services they might be completely self-supporting. You see, it becomes involved. Eventually somebody has to pay for this. It must be the cash customer who is subsidizing the Government eventually, is it not?

DR. McPHAIL: I couldn't rightly say.

THE CHAIRMAN: The dentist is going to have an income of X dollars a year, is he not, to live, and to have the standard of living that he thinks he ought to have by virtue of his professional status in the community; is that right? I mean, I don't want to debate the thing with you. Is that not common ground?

DR. McPHAIL: I couldn't say, sir; whether he would be satisfied with the income which he would have if he didn't participate or whether he did participate.

THE CHAIRMAN: Everybody looks forward to having an income of some kind and when they build a tariff do you anticipate that so many working hours in a



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4 year, providing you get paid, you will have X dollars
5 at the end of the year, that is your compensation for
6 your work.

7 DR. McPHAIL: I don't feel I can speak
8 for the profession.

9 THE CHAIRMAN: Well then, if the dentist
10 has to provide part of his time at a lower rate to
11 achieve the same result, therefore he must increase the
12 rate to those who are paying for that or accept the
13 loss of income. I assume he must have a certain income.
14 Eventually the subsidization comes back to the private
15 individual who is paying the shot. You follow that?

16 DR. McPHAIL: No sir, because I am not
17 clear that he rather, he would be willing to accept X
18 dollars, X dollars less what he pays out or what he
19 loses through supporting this program and accept that
20 as his income.

21 THE CHAIRMAN: It is not only the
22 dentist, it is the doctor and lawyer and anyone else
23 who subsidizes social aid through taking reduced fees.

24 COMMISSIONER McCUTCHEON: Could I ask
25 this question: you said you total about 20% of this
26 group, 10,000. Does that mean there are 10,000 people
27 in Alberta who want to go to the dentist and are willing
28 and able to pay and because you are looking after this
29 group of 10,000 - are you looking after all the people
30 who want to go to the dentist under this scheme or not?

DR. BROOKS: I think we are looking
after everyone. Everyone who wishes dental care receives
it, yes.



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4 COMMISSIONER STRACHAN: I think, sir,
5 I am not attempting to answer this; I imagine the way
6 the profession feels is this: they are going to have to
7 render a certain amount of services to this group anyway
8 and if they haven't this arrangement they are going to
9 have to do it for nothing at all.

10 DR. BROOKS: True, sir, and on the
11 administration we don't feel the Government was imposing
12 upon us. We volunteered to take this on. We thought
13 we could administer it better than the Government; run
14 it better and more efficiently and run it to the satis-
15 faction of our men. I think we have proven that with
16 our overhead costs. However, there was no compulsion
17 on any dentist to partake in this, to get into this
18 arrangement. I am very proud that they have taken part
19 in it, almost to a man and are contributing to a dental
20 program of this type.

21 COMMISSIONER STRACHAN: That group who
22 seek service, do they seek it regularly?

23 DR. BROOKS: Now, there, I can't say
24 if person A comes in this year and comes next year and
25 the next year. We haven't done a survey on that, but
26 we do know there are families in this who are on a six-
27 month recall and are quite interested in their dental
28 health and will co-operate. Others you see on an emer-
29 gent basis, and they don't care until they have another
30 toothache.

31 COMMISSIONER STRACHAN: Is the great
32 percentage of this work on an emergent basis?

33 DR. BROOKS: I think Mr. Furnell could



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3 answer that. He is our administrator.

4 with a view of MR. FURNELL: Quite a large part is of
5 an emergent nature. I would say also a large part are
6 getting good dentistry on the basis where they come back.

C/JO/dpw 7 COMMISSIONER STRACHAN: We are aware
8 of the arrangements at the present time for the training
9 of the dental auxiliaries in Alberta. What are the
10 future prospects for dentists in private practice to
11 secure a hygienist?

12 DR. BROOKS: There is most definitely
13 a need for hygienists, and we have repeatedly requested
14 the Government for hygienists, and all we can do now as
15 the Act stands is try to have the Government change the
16 Act so that we become eligible for these hygienists,
17 but right now we have to get them from Prince Edward
Island or Ontario.

18 COMMISSIONER STRACHAN: It strikes me
19 you are extending favours to the Government but not
receiving much consideration from them.

20 DR. BROOKS: I would agree.

21 COMMISSIONER STRACHAN: With respect
22 to dental assistants, what has the profession done to
23 train dental assistants?

24 DR. BROOKS: We have set up by private
25 practitioners a course of study to train girls, usually
26 high school girls, but frequently widows or girls wishing
27 to change their jobs. We train them so that they are
28 competent dental assistants, even at night, so that while
29 they are possibly going to school or enjoying employment
30 in one field and they wish to get into a dental office,



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3 why we train them at night in our own private offices
4 with a course of study and lectures.

5 COMMISSIONER STRACHAN: In groups?

6 DR. BROOKS: Yes, in groups. Sometimes
7 two or three groups. It has been an onerous task on our
8 particular Chairman in a couple of years' instances.

9 COMMISSIONER STRACHAN: How widespread
10 has that been?

11 DR. BROOKS: There is also a correspon-
12 dence course.

13 COMMISSIONER STRACHAN: In Edmonton,
14 Calgary; or one or both?

15 DR. BROOKS: Yes, we have a correspon-
16 dence course, too, in Edmonton or Calgary where these
17 are conducted and then we would put on, say, a two or
18 three-day program two or three times a year to bring in
19 the correspondence students and often they are put up at
20 our expense or somehow or other they are looked after.

21 COMMISSIONER STRACHAN: Do you feel you
22 have brought about an improvement in the situation?

23 DR. BROOKS: Yes, very definitely.

24 COMMISSIONER STRACHAN: Has there been
25 any effort made with the Government, again, in having
26 any training at vocational schools?

27 DR. BROOKS: Yes, we have recommended
28 that, sir.

29 COMMISSIONER STRACHAN: What considera-
30 tion has it received?

DR. BROOKS: I do not know, but we have
had nothing definite. I do not know what consideration



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3 they are giving it, but there has been nothing concrete.

4 COMMISSIONER STRACHAN: Coming to the
5 subject of dental practice in hospitals, page 20. Are
6 dentists permitted to admit patients to hospitals in
7 this province?

8 DR. BROOKS: Jointly admit patients,
9 yes.

10 COMMISSIONER STRACHAN: Jointly with
11 the physician?

12 DR. BROOKS: Yes, with the physician,
13 yes.

14 COMMISSIONER STRACHAN: And discharge?

15 DR. BROOKS: Discharge entirely.

16 COMMISSIONER STRACHAN: Then, are there
17 any dentists on hospital staffs?

18 DR. BROOKS: A great number, yes,
19 although this, again, is a local thing. Could I answer
20 for Calgary as an Edmontonian?

21 In Calgary, we have two hospitals. It
22 started out pretty well on a personal basis. There was
23 one dentist or two dentists on staff to attempt to render
24 the patient a full health service. It was shown from
25 just these two that the patients were not getting a
26 complete health service unless there was a dentist on
27 the staff. So the other large hospital in Calgary then
28 took on a couple of dentists. This has grown to where
29 there are possibly 40 or 50 dentists on staff in one
30 hospital in Calgary and they are on staff in all hospitals
in Calgary but one, and in all hospitals these 40 or 50
dentists are a sub-division of the Department of Surgery



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4 so that the medical doctor who, I think, rightly consi-
5 ders the hospital his castle -- and it should be that --
6 we are under the Department of Surgery, but in no instance
7 have any requests we have made been refused, and we are
8 most happy to think so and the patient has received a
9 better service.

10 We have instituted in the hospitals an
11 emergency treatment service, 24 hours a day, all year,
12 one dentist a week, turn-about on a rotating basis.
13 The dentist looks after all emergent care in the hospital
14 at any hour and looks after, also, out-patients who
15 present at the hospital for emergent treatment.

16 I do not think that there could be many
17 improvements on the situation as it exists, which is
18 rather unique, I think, in Canada, either that the
19 dentist could admit entirely on his own because the
20 dentist rightly knows that before he can do any surgery
21 under general anaesthetic that it is a standard law in
22 the hospital that all patients have to have a complete
23 physical examination before they are given a general
24 anaesthetic. So that if we could admit directly, it
25 would save the medical men an inconvenience, and it
26 would be more convenient.

27 Also, we feel that if there were beds
28 set aside in a dental wing in the new hospitals being
29 built, we could get those beds full and run them at an
30 efficient bed occupancy rate.

31 We are very pleased that in the new
32 hospitals that are being constructed in Alberta, by and
33 large in the larger hospitals we have dental wings with

gives the hospital the case -- and it should be that
we are under the Department of Surgery, but in no way
have any requests we have made been refused, and we are
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would be more convenient.

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We are very pleased that in the new



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3 complete dental chair set-up. We can do any dental
4 repair procedure or restorative procedure called upon
5 in this hospital. In our chronic hospitals, we also
6 have a dental operating room, as we call a dental opera-
7 tory set-up completely equipped with all instruments in
8 each chronic hospital.

9 COMMISSIONER STRACHAN: Where you can
work under general anaesthetic, if necessary?

10 DR. BROOKS: General anaesthetic, if
11 necessary, or local, or without anaesthetic. And,
12 contrary to what it is in most hospitals, the eye, ear,
13 nose and throat men usurp it, but we have a dental chair
14 in a dental wing.

15 COMMISSIONER STRACHAN: Is this work
done on a voluntary or remunerative basis in hospitals?

16 DR. BROOKS: What type work, sir? The
17 emergent treatment?

18 COMMISSIONER STRACHAN: Well, you diffe-
19 rentiate.

20 DR. BROOKS: All right. If we admit
21 our patients to hospital, we charge our patient the
22 emergent service. If I am called this week and I am
23 called to hospital, I bill the out-patient, if it is an
24 out-patient; and if it is an in-patient, I will bill
that in-patient.

25 If I have been called as a consultant --
26 if the hospital calls you, you may or may not be paid
27 because hospitals have their patients, just like the
28 medical men. I mean, we are in there, and this is part
29 of our responsibility to the hospital and we work on the
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3 same basis as the medical doctor in that regard, and
4 are subject to the same disciplines, to the same commit-
5 tees, etc., etc.

6 COMMISSIONER VAN WART: If a dentist
7 has a private patient in his office who needs an anaes-
8 thetic and hospital admission, does that dentist have
9 any difficulty in getting his patient into the hospital?

10 DR. BROOKS: Oh, yes sir, because there
11 is a shortage of beds and our dental cases are, generally
12 speaking, elective. An emergent dental case is judged
13 on its merits, as all emergent cases are. If you had a
fractured jaw, you are in the hospital somewhere.

14 COMMISSIONER VAN WART: If it is an
15 emergent case, does the dentist carry that case himself
16 into the hospital, or must he turn it over to a dentist
17 on staff in the hospital? This is a private patient I
am talking about.

18 DR. BROOKS: Oh, the dentist must be on
19 staff, yes.

20 COMMISSIONER VAN WART: Well now, if
21 that dentist wants that patient to have an anaesthetic
22 and he wants to do the work himself, where would he go
23 to get it done?

24 DR. BROOKS: If the dentist is not on
25 staff?

26 COMMISSIONER VAN WART: Yes.

27 DR. BROOKS: He would have to do that
in his own office.

28 COMMISSIONER VAN WART: Then, general
29 anaesthetics are given in the dental offices?
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4 DR. BROOKS: No, sir -- frankly -- well,
5 they are, but very rarely. Frankly, the dentist who is
6 not on staff whose patient required that type of treat-
7 ment usually refers them to one of the four or more of
8 them. In Calgary, I think perhaps 70 out of our men
9 are on staff. The whole 100 could be on if they wished
10 to apply and meet the requirements, but some do not wish
11 to be on.

12 COMMISSIONER VAN WART: Do you find in
13 practice that private patients entering the hospital
14 have any difficulty in obtaining an anaesthetist to
15 give the anaesthetic?

16 DR. BROOKS: None.

17 COMMISSIONER VAN WART: None?

18 DR. BROOKS: They may work very late
19 and your case may be done at 2 o'clock in the afternoon,
20 but it is done, yes.

21 COMMISSIONER VAN WART: Is it done at
22 6 or 7 in the morning?

23 DR. BROOKS: By law they are not allowed
24 to start before 8 o'clock in Edmonton, unless it is an
25 emergency.

26 COMMISSIONER VAN WART: Is that a statute
27 or a regulation from the Department of Health that regu-
28 lar work cannot start before 8 o'clock?

29 DR. BROOKS: Unless it is an emergency,
30 I know that is so. I do not know where the regulation
came from, I am sorry, sir.

COMMISSIONER VAN WART: Does that apply
to all hospitals?



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DR. BROOKS: I do not know that, either, sir. I know it does to the two major hospitals in Edmonton hospital, we have

senior students COMMISSIONER VAN WART: Is that a local regulation from the hospital; do you know?

DR. BROOKS: No, I do not know. I think it is a provincial statute. It is just local, according to some medical men who are in the audience.

COMMISSIONER VAN WART: It is a local regulation?

DR. BROOKS: Yes.

COMMISSIONER STRACHAN: What is the situation in Edmonton?

DR. YOUNG: I think there are only six or eight dentists on staff in Edmonton hospitals. There used to be more, but due to the shortage of beds in these hospitals, dentists found they could not get their patients admitted. At the present time, there is not so much work done in the hospitals here as could be done.

COMMISSIONER STRACHAN: Have you a similar dental set-up in hospitals?

DR. YOUNG: Yes, similar, but not with the numbers they have in Calgary.

COMMISSIONER STRACHAN: Now, with these favourable conditions in the hospitals, is there much work done for retarded children in that general group?

DR. MacLEAN: I might answer that, sir. At the University Hospital, we have a staff of nine in a Department of Dentistry, and there we do considerable work in the handicapped people. We have a schedule, that



DR. BROOKS: I do not know that, either

and I know it goes to the two major hospitals in

Edmonton.

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work in the handicapped people. We have a schedule, that



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3 is a dental service, available every day in the week.
4 And, of course, at the University Hospital, which is a
5 teaching hospital, we have block assignments for our
6 senior students as well as for the instructors. But
7 there is considerable work done on the handicapped
8 children at the University Hospital.

9 COMMISSIONER STRACHAN: And who pays
10 for that service?

11 DR. MacLEAN: Those who can afford are
12 billed and I believe there are some funds to look after
13 some of the other handicapped people -- polio funds and
14 such.

15 COMMISSIONER STRACHAN: Thank you.
16 Just one more question, sir.

17 Regarding the question of research,
18 from what source should financial support for research
19 come?

20 DR. MacLEAN: Mr. Chairman, I think the
21 sources in Canada at the moment are National Research
22 Council under which we have an associate committee on
23 dental research, and then the National Health and Welfare
24 Department.

25 Now, the National Research Council, our
26 associate committee on dental research, had been in exis-
27 tence for, I believe, since 1944 or 1945. It has
28 increased in its scope and in the amount of research
29 that it supports.

30 Under National Health and Welfare, this
would include research of a clinical nature. The
National Research Council, of course, I am sure you



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3 understand, is for research in basic science and what
4 we call "pure research".

5 In Alberta, at the University now we
6 have some nine research projects in progress. About six
7 of these are under N.R.C. support. The others are under
8 the support of the National Health and Welfare funds.

9 There may be sources such as private
10 foundations. On rare occasions, the National Institute
11 of Health of the United States will support a project,
12 and probably this is a carry-over from someone who had
13 done research in a graduate program in the United States
14 and continues the same project in Canada.

15 These are the sources, sir.

16 COMMISSIONER STRACHAN: And how many
17 men have you in Alberta capable of carrying on dental
18 research?

19 DR. MacLEAN: Well, at the moment we
20 might have about five at the University. We certainly
21 need more men with special training along research lines
22 to return to our University to do this type of work, and
23 also to probably do some part-time teaching, because
24 they are very stimulating teachers when they are in the
25 research field. We would hope to obtain more men in
26 the future.

27 COMMISSIONER STRACHAN: I think that
28 is all, Mr. Chairman.

29 COMMISSIONER VAN WART: Turning to page
30 12, section 25. It reads:

"The Committee favours a co-insurance



in Alberta, at the University now we

have some nine research projects in progress. About six
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There are two research projects

in the field of the

and now, but in the field of carrying out research

the field of the

might have about a half of the field. We normally

have been working with various research groups and have

to be in the field of the

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or indemnity type of plan in preference to a comprehensive type because the former encourages the prevention of dental disease and maintenance of quality of dental services".

Could you elaborate a little on that?

DR. RASMUSSEN: I think we should stress that what we are talking about is a pilot study and that we have not necessarily made up our minds to any type of plan as it might appear.

COMMISSIONER VAN WART: It is not the type of plan; it is the statement that it encourages prevention of dental disease and so on -- this co-insurance type. Would you elaborate a little on that? It is given as your reason for the co-insurance type.

DR. RASMUSSEN: Well, we feel that if a person has a part in maintaining his own health, a personal part, that he would be more interested than he would be if he were being given the thing holus bolus.

It would appear that people are not all too interested in prevention, and that really when all is said and done they are only interested in emergency service. They wait until they have a toothache and then they come to us for treatment.

We feel that possibly if our findings in a pilot study show us that this is right, then because they are going to be putting up a little bit of the cost or a lot, or whatever the finding might be, that they might be more interested in maintaining their own health.

COMMISSIONER VAN WART: Do any of the



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mental disease and maintenance of
quality of mental services.

DR. FAYUSSE: I think we should...

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... and a point in his own mind, a
... that he is more interested than in
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we feel that possibly it can be
in a pilot study that this is what we want to
... and going to be putting up a little bit of the
... or whatever the thing might be, that they
... in mind and some other things



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3 commercial carriers have dental plans, or where you
4 can buy dental insurance from any commercial carriers?

5 DR. RASMUSSEN: In Canada I am not aware
6 of any that are operating at the present time. I think
7 there are one or two being mooted in the United States,
8 but whether they are in operation I do not know.

McH/dpw
9 COMMISSIONER VAN WART: The same argu-
10 ment you are putting forward on co-insurance here would
11 be applicable to a commercial carrier who sells this
12 type of insurance entirely?

13 DR. RASMUSSEN: Yes, it possibly would
14 except we envisage a plan which would be absolutely non-
15 profit such as your M.S.I.

16 COMMISSIONER VAN WART: Non-profit
17 would not enter into co-insurance giving better preven-
18 tive dentistry and so on?

19 DR. RASMUSSEN: No, it would not.

20 COMMISSIONER VAN WART: That is the
21 point I am trying to establish, if co-insurance is going
22 to give you better preventive dentistry it is advisable
23 rather than not having co-insurance.

24 DR. BROOKS: We think that and we say
25 again this is a private study and that we do not know
26 anything about this sort of thing. Possibly this is the
27 only type of thing we could do to be fair to the parti-
28 cipating group without putting their premium too high.
29 This way we can do this and absorb, if we have our
30 Dental Association as a private group, we can absorb
that but if we have a co-insurance - well, this gives
us an opportunity to find out where we go on this



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3 experimental thing and that is why we run it this way.

4 COMMISSIONER VAN WART: A service type
5 of club, as far as the patient is concerned he knows
6 exactly what he is paying and under the co-insurance he
7 does not know exactly because it varies with the indivi-
8 dual dentist how much co-insurance is in the plan.

9 DR. BROOKS: There is another variable
10 here that is very difficult to assess and that is that
11 medically, I think we know there will be a certain percen-
12 tage of people take ill this year but dentally, and in any
13 group of people you want, we know about 95% of them
14 are afflicted with dental disease. We are treating 100%
15 disease whereas medically you are only treating a propor-
16 tion and people who are healthy can absorb the cushion of
17 those who are ill. Dentally when we go into a new group
18 we have 95% of the people needing treatment so what are
19 we going to do in that case because in the first year
20 you will be bankrupt.

21 COMMISSIONER VAN WART: You may not have
22 this until there is an educational program.

23 DR. BROOKS: This is a different group
24 here, the other 20%, this is a different type of person
25 who is possibly right now getting adequate dentistry in
26 a great many instances.

27 DR. RASMUSSEN: We feel too that some
28 of these people when they come into the plan they may
29 have dentistry that they have not had done over the
30 years that perhaps should have been done and when they
enter a plan they may say "Here is a chance to get it all
done". These are things that they have not looked after



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for many years.

COMMISSIONER VAN WART: In your mobile clinics, what follow-up work do you have? A patient comes to the mobile clinic today and the clinic is going to move on so what is the mechanism of follow-up?

DR. YOUNG: There is no follow-up in this program unless it is requested, the community requests this service at some future date.

COMMISSIONER BALTZAN: Just one question, gentlemen. On your designation F.I. I see you have a Certified Dental Mechanics Act of Alberta and my question is, they are synonymous with what is called denturists in other areas?

DR. BROOKS: Yes.

COMMISSIONER BALTZAN: And the training, what formal training do they get?

DR. BROOKS: Nil.

COMMISSIONER BALTZAN: They are do-it-yourself people?

DR. BROOKS: Yes, sir.

COMMISSIONER BALTZAN: That is not exactly the kind of thing that a profession invites?

DR. BROOKS: No.

COMMISSIONER BALTZAN: Do you think it will bring us a little closer to where people might be able to get store teeth?

DR. BROOKS: We certainly feel it is a regressive step from all aspects and the patient is certainly going to be the loser in this legislation.

COMMISSIONER BALTZAN: In what way can



COMMISSIONER BARTON: In your mobile

clinics, what follow-up work do you have? A patient
comes to the mobile clinic today and the clinic is
going to move on so what is the mechanism of follow-up?
DR. BROWN: There is no follow-up in
this program unless it is requested, the community
receives this service at some future date.

COMMISSIONER BARTON: Just one question

please. On your designation, I see you have a
Certified Dental Technician out of Alberta and my guest
is, they are synonymous with what is called dentists
in other areas?

DR. BROWN: Yes.

COMMISSIONER BARTON: And the training

and formal training, do they get?

COMMISSIONER BARTON: They are doing

yourself practice?

DR. BROWN: Yes, sir.

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exactly the kind of thing that a profession involves

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progressive step from all aspects and the patient is

certainly going to be the focus in this legislation

COMMISSIONER BARTON: In what way can



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3 there be harm to people from that practice?

4 DR. BROOKS: The patient is under the
5 apprehension that they are receiving qualified treatment
6 and we feel they are not. We have had patients come to
7 us and say that they have been to Doctor so-and-so where
8 Doctor so-and-so has admittedly and knowingly had Grade
9 8 education and has been a laboratory technician and
10 possibly not a very competent laboratory technician.
11 These people feel they had been to a dentist.

12 THE CHAIRMAN: Are they entitled to use
13 the designation of Doctor?

14 DR. BROOKS: No, but we feel it is
15 possibly encouraged.

16 THE CHAIRMAN: The public have a
17 tendency to use the expression?

18 DR. BROOKS: Yes.

19 COMMISSIONER BALTZAN: Thank you very
20 much.

21 COMMISSIONER GIRARD: On page 21 you
22 speak about the cleft palate diagnostic and habilitation
23 centres; this, I understand, is a voluntary affair. Now,
24 I do not want to know if it has a subsidy or not but I
25 just want to know how these centres are set up and who
26 participates?

27 DR. BROOKS: We have orthodontists,
28 dentists, dental surgeons, eye, ear, nose and throat,
29 speech therapists, social service workers, specialists
30 in internal medicine, orthopaedic surgeons. I may have
missed out one or two but I can give you the complete
list. We have a full team on this.

BOOKS: The patient is under the

and we feel they are not.

us and say that they have been to Boston and that when
Boston comes back has admitted and knowingly had in the
education and has been a laboratory technician and
possibly not a very competent laboratory technician.
These people feel they had been to a dentist.

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the designation of dentists.

DR. BROWN: No, but we feel it is

possibly recognized.

THE CHAIRMAN: The dentist have

reference to the expressions

THE CHAIRMAN: There you were

about.

THE CHAIRMAN: On page 21 you

ask about the chief physician and his position

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in internal medicine, orthopedic and general. I say none

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COMMISSIONER GIRARD: And this is all voluntary?

DR. BROOKS: Yes.

COMMISSIONER GIRARD: At least I think you say you have certain service clubs that sponsor these clinics.

DR. BROOKS: Yes, you might as well say it is complete benevolence on their part.

COMMISSIONER GIRARD: You have them in two hospitals so far?

DR. BROOKS: Yes.

COMMISSIONER GIRARD: How many patients would you see in these centres?

DR. YOUNG: It is not treatment, it is purely diagnostic.

DR. MacLEAN: Rather a few patients, I am sorry I do not know the number.

COMMISSIONER GIRARD: Who would refer these patients to these diagnostic centres?

DR. BROOKS: Dentists, medical, paediatricians.

COMMISSIONER GIRARD: School people?

DR. BROOKS: Yes, public health nurses.

COMMISSIONER GIRARD: After they go through the diagnostic centre is there some way they can get the treatment if they cannot pay for it?

DR. BROOKS: Yes, but they cannot handle all the cases so they take it on a "Well, this is a most deserving case" and do that as best they can. It is rather pathetic at times that you diagnose a case for



voluntarily?

Yes, I think so.

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these clinical

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say it is a concrete phenomenon on their part.

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3 a parent and cannot do anything.

4 COMMISSIONER GIRARD: There is no
5 follow-up from this diagnostic centre?

6 DR. BROOKS: In some cases none but
7 there are in a great many cases a follow-up on a private
8 basis and then the patient is returned to the junior
9 Red Cross Hospital where the group meets and is observed
10 periodically and the diagnosticians will make suggestions
11 for stop-gap treatment.

12 COMMISSIONER GIRARD: Do you have any
13 figures on how many of these cases that were diagnosed
14 that have gotten treatment subsequently?

15 DR. BROOKS: Yes, but I have not got it
16 with me.

17 COMMISSIONER GIRARD: I think if you
18 could send that to the Commission it would be helpful.
19 This is a very interesting clinic and especially when
20 it is done on a voluntary basis; there is a great need
21 for this sort of thing.

22 THE CHAIRMAN: The figures both ways,
23 those who have been diagnosed and not taken care of.

24 COMMISSIONER GIRARD: Thank you very
25 much.

26 COMMISSIONER FIRESTONE: I take it
27 from nodding your head that the information will be
28 supplied to us?

29 DR. BROOKS: Yes sir, we will see that
30 is done.

COMMISSIONER FIRESTONE: Thank you very
much. Dr. Brooks, or any other of your associates, I

ai qone.



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would like to ask a few questions on prepayment of dental care services. Would you like to deal with this question or designate any of your colleagues to deal with it so I can address the questions to them or shall I address the questions to you?

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DR. BROOKS: If you would direct them to me.

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COMMISSIONER FIRESTONE: Are you in favour of the principle of prepayment of dental services?

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DR. BROOKS: I think Dr. Rasmussen can handle that.

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DR. RASMUSSEN: I think we might be in favour of prepayment of dental services, yes.

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COMMISSIONER FIRESTONE: You say the answer is yes and you proceed in your brief in paragraph 22 to say that you are in the process of developing such a plan here in the Province of Alberta. You say, further, that in order to develop such a plan you may require financial assistance for research aspects of such a program. Could you explain what financial assistance you have in mind in this particular context?

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DR. RASMUSSEN: As you know, we do not really, as a profession, have as many statistics as we would like to have. In order to get this program developed, any type of prepayment plan, you do need statistics in order to set up the costs of operating such a program. Now, to develop this informational or statistical analysis of the program you require money; that is what we are talking about.

29

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COMMISSIONER FIRESTONE: Well, you say



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3 you need money for statistical research; do you know
4 how much money and from whom you expect to get the
5 money?

6 DR. RASMUSSEN: We are developing this
7 information at the present time and we have not come up
8 with all of the answers as yet on this. I really could
9 not say how much money we would require or where we
10 would expect to get it.

11 COMMISSIONER FIRESTONE: Are you sugges-
12 ting the lack of funds is delaying the formulation of
13 such a program?

14 DR. RASMUSSEN: We have not reached the
15 point where we have felt that we had enough information
16 that we could go to anyone and ask for funds. We cannot
17 say that so we have not asked anyone.

18 COMMISSIONER FIRESTONE: Paragraph 24
19 you say:

20 "A special committee of the Alberta
21 Dental Association has spent two-and-a-
22 half years planning a prepaid dental
23 health program ---"

24 So you have spent two-and-a-half years
25 and have not yet reached the stage of knowing what you
26 need in order to develop a program. Am I right in this
27 understanding?

28 DR. RASMUSSEN: Well, initially to
29 develop the principle of the program requires quite a
30 little bit of education of our own men who are involved
in this and all our committee people. We have had a
few changes in our committee members due to various

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4 that helped to make this take a little longer than it
5 might otherwise. All the men on these committees are
6 in private practice and it is not always possible to
7 get the meetings just as quickly as we would like to have
8 them. It does take a little more time than it would if we
9 could devote all our time to this program.

10 COMMISSIONER FIRESTONE: You are talking
11 in paragraph 24 of a private study; what is the present
12 stage of the planning of that private study?

13 DR. RASMUSSEN: We presently have
14 discussed the idea of such a scheme with one or two
15 groups of people in this province, interested groups
16 who would be interested in participating in such a
17 scheme. We are trying to develop a plan after discussing
18 with these interested groups their views and we are
19 trying to develop a plan which will be to the mutual
20 happiness of all the people concerned, both the member
21 of the plan and the professional provider of the service
22 and our Association.

23 COMMISSIONER FIRESTONE: In carrying
24 on these discussions with one or two groups, perhaps
25 more than that, have you had an outline as a basis for
26 discussion of what this private plan would cover?

27 DR. RASMUSSEN: Now, do you mean what
28 actual services it would provide?

29 COMMISSIONER FIRESTONE: What actual
30 services it would provide, how the plan would work, what
it would cost. After all, when you talk to somebody
and say "Would you like to participate in the plan?" they

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3 probably would say "What would it involve, how would it
4 operate, what would I have to pay, what are the basic
5 ingredients for the plan being developed as a whole?".
6 Have you developed this as yet?

7 DR. RASMUSSEN: Not completely.

8 COMMISSIONER FIRESTONE: Have you
9 developed it incompletely?

10 DR. RASMUSSEN: We have some information.
11 We do not know what it will cost because it is one of
12 the big reasons for the pilot study and we will have to
13 make an intelligent guestimate as far as the cost of
14 offering the plan is concerned. We have to go out and
15 actually do a survey of the need before the plan is
16 instituted and this presents some problems.

17 As far as what it will cover, again,
18 from correspondence and from study of other plans, it
19 would appear that possibly it would initially, at least,
20 have to have certain exclusions until we had established
21 some cost figures.

22 COMMISSIONER FIRESTONE: Well, did I
23 understand you correctly to say that one of the things
24 that may be required before you can proceed with the
25 pilot study is to have a survey of things?

26 DR. RASMUSSEN: This would be desirable
27 but whether it could be accomplished or not we cannot be
28 sure.

29 COMMISSIONER FIRESTONE: Are you
30 planning to conduct a survey before you go ahead with
the pilot project or are you not?

DR. RASMUSSEN: I rather think we



probably would say "What would it involve, how would it operate, what would I have to pay, what are the basic ingredients for the plan being developed as a whole?" Have you developed this as yet?

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developing your plan. Could we have that?

DR. RASMUSSEN: Yes, most assuredly.

COMMISSIONER FIRESTONE: If, in case, you don't have the plan in operation by that time, but you have had certain experiments as a result of your discussions, could a memorandum be produced for the Commission just summarizing the experience. You may decide not to proceed with the plan after. We would like to know why and based on the discussion of the experiment which you have, would you be in a position to let us have that?

DR. BROOKS: I think we could so far. I think we had one group, we tried to get a pilot group of between 1,000 and 1,200 people, and we had this group and this group, some members of the group, didn't want to come in, some did. One had all his teeth removed and didn't want to come in the plan. We had trouble on this, to get what we wanted. We want an ideal type of group so we can do an accurate study. I think we have had two groups.

COMMISSIONER FIRESTONE: That is it.

DR. BROOKS: We have had some experience.

COMMISSIONER FIRESTONE: That is what we would like. If some plan fails we want to know why. If we are to advise on the possibility of a dental prepayment program we ought to know what efforts have been made; whether they have been successful. If they have failed we would like to know what has caused the failure or the success. Yes.

DR. RASMUSSEN: One observation we have



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made so far as this project breaking down has been that some of the people have said, "We are presently spending not much money or very little money on dentistry". I think this is because of education and they think why should we bother? That is part of the trouble, apparently.

COMMISSIONER FIRESTONE: Would that also apply to children under 14 years?

DR. RASMUSSEN: Pardon?

COMMISSIONER FIRESTONE: Are parents not interested in the dental health of their children? Is that your experience?

DR. RASMUSSEN: The attitude of some of the public would appear to be that baby teeth don't need to be filled, we will leave them and when they hurt we will take them out. They don't realize when you do that you are creating many problems for later life. I think the public ought to be educated to the fact we must retain these deciduous teeth and that the state of the mouths and the state of the health - I don't think generally the public appreciate that should be done.

COMMISSIONER FIRESTONE: Whose responsibility is it to educate the public?

DR. RASMUSSEN: We feel it is the Government's responsibility. As far as prevention is concerned, when they are in our office our treatment, preventive treatment, is our responsibility.

COMMISSIONER FIRESTONE: You feel the dental profession has no responsibility in contributing to the education of the public of dental needs in Canada?

DR. RASMUSSEN: I think we should

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MR. RASMUSSEN: We feel it is the Govern-

ment's responsibility. As far as prevention is concerned

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COMMISSIONER FIRESTONE: You feel the

dental profession has no responsibility in continuing

to the education of the public of dental needs in Canada

MR. RASMUSSEN: I think we should



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4 contribute what we can. Speaking of our functions in
5 our office but when - certainly we can promote such
6 things as fluoridation and so forth.

7 COMMISSIONER FIRESTONE: Because, in
8 fact, you have been telling us you think quite a bit
9 could be done in this field. Would you say it is not
10 just the Government's responsibility; the profession has
11 some?

12 COMMISSIONER STRACHAN: I think, Dr.
13 Firestone, they answered that this morning.

14 COMMISSIONER FIRESTONE: If I may just
15 get the answer from Dr. Rasmussen.

16 DR. RASMUSSEN: Would you rephrase the
17 question?

18 COMMISSIONER FIRESTONE: I think it is
19 not just Government's responsibility, but also the respon-
20 sibility of the dental profession.

21 DR. RASMUSSEN: I think that any health
22 matter should concern anyone in health, shouldn't it?

23 COMMISSIONER FIRESTONE: Could I just
24 finish this point? You state any health matters are the
25 concern of anyone - we are concerned here with dental.

26 DR. RASMUSSEN: Dental health matters.

27 COMMISSIONER FIRESTONE: Should also
28 concern all?

29 DR. RASMUSSEN: Any dental health matter
30 naturally must concern dentists.

COMMISSIONER FIRESTONE: Thank you very
much.

COMMISSIONER BALTZAN: Just one point,

contribute what we can. Speaking of our functions in
our office but when - certainly we can promote such
things as fluoridation and so forth.

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COMMISSIONER FIRESTONE: If I may just

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COMMISSIONER FIRESTONE: Should also

DR. PASSMANN: Any dental health matter



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4 I think that your difficulty in answering this question
5 that I want to ask you is not the profession at a disad-
6 vantage, is it not the kind of thing you would like to
7 do but mainly because it might be interpreted on the part
8 of the public that you are just drumming up trade?

9 DR. RASMUSSEN: Yes, they might interpret
10 it that way.

11 COMMISSIONER BALTZAN: That is one of
12 your big difficulties. On the other hand you would be
13 prepared and willing as part of your function to do all
14 the prevention, discussion, education and treatment.

15 DR. RASMUSSEN: Yes.

16 COMMISSIONER BALTZAN: Thank you.

17 COMMISSIONER FIRESTONE: If I may turn
18 to paragraph 3 in which you outline certain principles.
19 In sub-paragraph 3 you state:

20 "By maintaining the dentist's privilege
21 to exercise professional discretion in
22 treatment planning without third party
23 interference".

24 Can you explain to us what you mean by
25 third party interference?

26 DR. RASMUSSEN: Of course, this applies
27 to dental health plans, and we feel if the dentist
28 recommends a certain treatment procedure to the patient
29 that he should be allowed to carry out that treatment
30 procedure without having a third party say to him "No,
you cannot proceed with that type of treatment, it
should be something else". We feel, after all, the
dentist has the answer in his office and should know what



I think that your difficulty in answering this question that I want to ask you is not the profession at a disadvantage, is it not the kind of thing you would like to do but mainly because it might be interpreted on the part of the public that you are just drawing up trade?

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3 needs to be done.

4 COMMISSIONER FIRESTONE: Who did you
5 have in mind by third party interference?

6 DR. RASMUSSEN: When we are talking
7 about a dental health plan we are thinking about the
8 administration of the plan, whether it be run by us, as
9 we feel it should be, or anyone else.

10 COMMISSIONER FIRESTONE: Thank you
11 very much, sir. You are visualizing a prepaid plan for
12 the Province of Alberta in the field of dental care,
13 assuming that your pilot projects are successfully
14 developed on a voluntary basis and administered by a
15 non-profit institution similar to M.S.I. applicable to
dentistry.

16 DR. RASMUSSEN: Operated by the dental
17 profession.

18 COMMISSIONER FIRESTONE: That is
19 correct, sir, yes. If there was to develop in the
20 Province of Alberta a prepaid medical care plan, and
21 then, at some stage also a prepaid dental care plan
22 that would be applicable to and available to the majority
23 of people in the Province of Alberta, and such a plan
24 would be - contributions to such a plan would be made
25 by the Province of Alberta, particularly for people who
26 couldn't afford to pay their share of the cost, with
those who could afford to pay, paying. Would your
Association support such a plan?

27 DR. RASMUSSEN: You mean a plan operated
28 by an overall organization? Is that what you are trying
29 to say?
30

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4 COMMISSIONER FIRESTONE: Let us assume
5 the Government of Alberta were to take M.S.I. as a
6 designated carrier and M.S.I. would have a division
7 which would perform the same sort of function as M.S.I.
8 runs for the dental profession. That is, instead of
9 having many designated carriers there would be one
10 carrier, but the one carrier may have several divisions,
11 one concerned with physicians, one concerned with dental
12 care, one concerned with prepaid drug service, and the
13 overall group directing the concerns of physicians, of
14 dentists, of pharmacists, all the groups of professions
15 involved instead of having many carriers, one carrier,
16 a carrier designated by the Government. Would you be
17 in favour of such a plan?

18 DR. RASMUSSEN: Could I ask Dr. Brooks
19 to answer that?

20 DR. BROOKS: No, we wouldn't.

21 COMMISSIONER FIRESTONE: Could you
22 explain why?

23 DR. BROOKS: For several reasons. One
24 is dentistry is different from medicine. The administra-
25 tion is directly connected, the administration of health
26 service is directly connected with the service the
27 patient receives and if the administration of the service
28 is not correct then the treatment is not correct.

29 We have carried on, as Dr. Strachan
30 inquired about earlier this morning, Dr. Firestone, this
welfare service plan in Alberta. The Alberta Dental
Association has done it. We have done it exceptionally
well. We feel we are experienced enough to run another
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DR. BARNES: Could I ask Mr. Brooks

to answer that?

DR. BROOKS: No, we wouldn't.

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1 says you get so much money, and therefore that much money
2 is going to affect what type of treatment the patient
3 receives, and that is not fair to the patient. Dentistry
4 is different, further from medicine, in that in dentistry
5 we are dealing with a recurring disease. Most dental
6 conditions render themselves to prevention and control
7 rather than treatment. Again if I may go back to a
8 question which you asked a while ago, when we support a
9 prepaid plan, we have educated a group and say "If you
10 will have your dental health and follow with proper nutri-
11 tional intake, proper oral hygiene your premiums can be
12 one-quarter of what they are". If you let your mouth go,
13 if some person has a dirty mouth and is not going to look
14 at a toothbrush, who is going to eat as he wishes, not
15 follow the advice your premiums will skyrocket. Our
16 profession leans itself to preventive education. I don't
17 think it does in medicine. We are quite a bit different
18 and we have had the experience of running one. We have
19 run one well. We feel we should still run it.

20 COMMISSIONER FIRESTONE: Would you
21 suggest that if there was a central administrative
22 agency with various divisions which is primarily
23 concerned with the financing aspect, leaving it up to
24 the profession to decide how to treat patients, you do
25 your practising, straight practice, that there would be
26 interference with the manner in which you operate, which
27 you practise, wouldn't the discretion still be left to
28 the dental profession to look after the patient. Its
29 function would be financed.

30 DR. BROOKS: No, I certainly say it
could not be effective because the financial agency says,



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4 "Here, this year you treated so many thousand people with
5 so many dollars, X dollars, and next year you can do a
6 little better, you can do it with X minus Y dollars,
7 and besides you have given birth to quite a few children,
8 you look after that besides". That happens. We have
9 seen it time and time again and then nothing can happen
10 but a deterioration of the quality of service. We feel
11 that there should be nothing but the best possible
12 service for everyone.

13 COMMISSIONER FIRESTONE: That is quite
14 understandable. I think we are all talking about the
15 same thing, we want to provide the best medical care
16 service or dental care service.

17 DR. BROOKS: You can't when someone has
18 hold of the purse strings that is not administrating and
19 not looking after the thing. What has he the money for
20 if he doesn't want control or why have it in a central
21 agency?

22 COMMISSIONER FIRESTONE: I presume the
23 dentists' profession would be participating in the
24 M.S.I. and therefore they would have a say in the matters
25 that concerned dentistry?

26 DR. BROOKS: We would have a say or a
27 fight, whichever way you like to put it. We would rather
28 have the money and we administer it. We think we could
29 give a better service.

30 COMMISSIONER FIRESTONE: Therefore you
feel there ought to be a duplication of administration
agencies if there was such, one for the doctors, one for
the dentists, one for the pharmacists, one for the nurses.

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Would it be efficient to have a lot of agencies and a lot of groups looking after their concerns?

THE CHAIRMAN: That is not what he said. He wants one for the dentists and he is not concerned about the rest.

DR. BROOKS: That is correct.

COMMISSIONER FIRESTONE: I think that answers my question.

THE CHAIRMAN: Thank you very much Dr. Woronuk and Dr. Brooks and gentlemen.

Dr. Strachan would like to know if any one of you gentlemen have anything further to add before you leave rather than you go away feeling that we didn't anticipate by questioning some point you wanted to discuss?

DR. WORONUK: Mr. Chairman, members of the Commission, I would like to thank you on behalf of the panel here and the members of the Alberta Dental Association for the opportunity we have been given to present this brief. I thank you.

THE CHAIRMAN: The next brief will be the University of Alberta Hospital.

We will take a short recess and go on with that.

--- A Short Recess.

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/JO/dpw

SUBMISSION OF THE UNIVERSITY OF ALBERTA HOSPITAL

Appearances: Mr. D.J. Avison
Dr. J.D. Wallace
Dr. Snell
Mr. G. Sherwood
Mr. W. Maday
Dr. D.R. Wilson
Miss J. Clark

--- EXHIBIT NO. 120: Submission of The University of
Alberta Hospital.

THE CHAIRMAN: Mr. Avison?

MR. AVISON: Thank you, Mr. Chairman.

Lady and gentlemen of the Commission, my name is Donald
Avison, Chairman for seven years of the Board of the
University of Alberta Hospital.

Our Board numbers seven. Two of the
members, the President of the University of Alberta and
the Dean of the Faculty of Medicine of the University
are statutory members. All others are appointed by and
serve at the pleasure of the Lieutenant-Governor in
Council.

Prior to my unpaid appointment as
Chairman, I worked for 42 years with the Imperial Oil
Limited, and on retirement was marketing manager for
Alberta, the Northwest Territories and part of the Yukon
and covered Mackenzie and Yukon areas many times. Before
returning to Alberta, I was marketing manager for Saskat-
chewan for 13 years.

THE CHAIRMAN: As I well remember!

MR. AVISON: Yes, sir, that is why I
put that in there.

Appearances: Mr. G. J. Avison
Dr. Shell
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4 The Hospital Board meet regularly at
5 least once a month, where all phases of the hospital
6 operation are discussed. The Board does not attempt to
7 run the day-to-day operation; that is the job of the
8 administrators who will be introduced to you in a few
9 minutes.

10 The principal concern of the administra-
11 tion of the Board is, and should be, the care of the sick
12 and that, as this Commission well knows, covers a wide
13 field plus teaching and research responsibilities.

14 We are assisted by several committees
15 who also all meet regularly and whose suggestions and
16 recommendations over the years have been of great help
17 with the result that in all Scottish modesty, if such a
18 thing exists, we have earned the reputation of being one
19 of the best treating and teaching hospitals in Canada.

20 However, we realize that we are not
21 perfect and the brief, questions and discussions during
22 this week and this Commission's report will, I feel sure,
23 be of great help to us over the coming years.

24 Naturally, any detailed knowledge I
25 may have had concerned the oil business, but many of
26 the same basic principles apply in any operation, particu-
27 larly dealing with organization and management.

28 Many of your questions will deal with
29 health matters, and I would respectfully request that the
30 members of the delegation with me today be allowed to
speak on behalf of the hospital.

2 I would now like to introduce them.
On my left, Dr. J.D. Wallace, Executive Director; Dr.

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least once a month, where all phases of the hospital operation are discussed. The Board does not attempt to run the day-to-day operation; that is the job of the administrators who will be introduced to you in a few minutes.

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4 Snell, Medical Superintendent; Mr. George Sherwood,
5 Business Administrator; Mr. Maday, whom you met yesterday,
6 I believe, Assistant Business Administrator; and Dr. D.R.
7 Wilson, Professor of Medicine of the University of Alberta
8 Medical School and representing the University of Alberta
9 in its close co-operation with the hospital, Miss Jeannie
10 Clark, Director of Nursing. We are at your service to
11 elaborate on any statements in our brief. Thank you Mr.
12 Chairman and Commissioners.

13 --- EXHIBIT NO. 120A: Copy of Chapter 92 - "An Act to
14 amend the University of Alberta
15 Hospital Act".

16 --- EXHIBIT NO. 120B: Copy of Chapter 36 - "An Act to
17 Consolidate and Revise the Law
18 relating to Hospitals and Hospitali-
19 zation Benefits".

20 --- EXHIBIT NO. 120C: 37th Annual Report, University of
21 Alberta Hospital.

22 THE CHAIRMAN: Dr. Wallace, please.

23 DR. WALLACE: Thank you, sir.

24 Mr. Chairman and members of the Royal
25 Commission, as the first hospital group that has appeared
26 before your Commission in Alberta we have adopted a foot-
27 ball tactic in our presentation today. Our first presen-
28 tation will be the presentation of the specific problems
29 of the University of Alberta Hospital relating specifically
30 to teaching and research.

As a member hospital of the Associated
Hospitals of Alberta, the general operation of our hospital
corresponds in detail with that of all other hospitals in
the province, and the thoughts that will be expressed on



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2
3 Friday by the Hospital Association are shared by this
4 hospital.

5 The second team or platoon that we will
6 bring on has been requested by the Commission. It is a
7 representative group of administrators from the four
8 hospitals in Edmonton. All of them are affiliated and
9 teaching in hospitals. Their problems are similar in
10 teaching and research, but to a lesser degree in the
11 University of Alberta Hospital.

12 I would therefore request that where
13 the term "affiliated teaching hospital" is used in this
14 brief, it might be specifically referred to the University
15 of Alberta Hospital.

16 In starting, I would also like to make
17 one correction in the brief and this is on page 5 in the
18 second last paragraph where reference is made to the
19 Act and it should be referring to the regulations under
20 the Hospital Insurance and Diagnostic Services Act.

21 SUMMARY

22 This brief will present the views of
23 the Board, Administrative Staff, and Medical Staff of the
24 University of Alberta Hospital in the following manner:

25 1. The Role of a University-affiliated
26 Teaching Hospital.

27 2. The Organization of the University
28 of Alberta Hospital.

29 3. Financing Arrangements under the
30 Hospital Insurance and Diagnostic
Services Act and the Alberta Hospitals
Act - Advantages and Disadvantages.



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Teaching hospital.
1. The Organization of the University
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Hospital Insurance and Diagnostic
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Act - Advantages and Disadvantages.



4.1 Conclusions and Recommendations
regarding:

A - The Existing Facilities and Methods
for Providing Personal Health Services.

B - Methods of Improving such Existing
Health Services.

C - The Correlation of any New and
Improved Program with Existing Services.

D - The Provision and Training of Ade-
quate Numbers of Personnel.

E - The Relationship of Existing and
Proposed Programs with Medical Research.

1 - That government hospital plans
recognize the special role of univer-
sity-affiliated hospitals and meet the
costs of patient care and of special
services in the educational and patient-
centred research fields.

2 - That government policies on taxation
and succession duties continue to recog-
nize the importance of voluntary donation
of funds in support of the development
of medical care.

3 - That the Hospital Insurance and
Diagnostic Services Act be amended by
deleting the words "or mainly" where
they appear in Section 7, Subsection
(3), Paragraph c.

4 - That the Regulations under the
Hospital Insurance and Diagnostic



4. Conclusions and Recommendations

For providing Personal Health Service
B - Methods of Improving and Extending
Health Services.

C - The Organization of any new and
improved program with existing health
D - The Provision and Training of Man-
power in the field of health.

E - The Relationship of Existing and
improved programs with health as an
F - That Government should continue

recognize the special role of univer-
sity-affiliated hospitals and when the
needs of patient care and of special
services in the education and patient

G - That government policies on health
and education should continue to recog-
nize the importance of voluntary health
of funds in support of the development
of health care.

H - That the hospital insurance and
disposable services not be limited by
altering the words "or primary" where
they appear in section 7, subsection
(3), paragraph c.

I - That the Regulations under the



Services Act be amended to allow special revenue mechanisms to be used in hospitals in which government payments do not provide adequate funds for a good standard of patient care together with the education and research program the hospital requires.

I might mention, sir, that the small letter (b) and (c) refers to the sub-paragraph in the Privy Council Order that designated the Commission's powers, and it was placed there mainly so that you could refer it back to the paragraph concerned.

B-(b) Methods of Improving such Existing Health Services.

Patient care in active-treatment, general hospitals is becoming more costly each year. Costs in a university-affiliated hospital are considerably higher than in a non-affiliated hospital. It is therefore recommended:

1 - That new-type facilities which have been proven to reduce costs of care be approved under the federal-provincial agreement: e.g. - self-care units, day hospital and night hospital facilities, clinical investigation units.

2 - That diagnostic out-patient services be approved as a benefit under the hospital insurance plan.

C-(c) The Correlation of any New and Improved Program with Existing Services with a View to Providing Improved Health Services.



special revenue mechanisms to be used in hospitals in which government pay-
a good standard of patient care together with the education and research program the hospital requires.

1. With respect to the sub-paragraph in the letter (b) and (c) refers to the sub-paragraph in the Army Council Order that designated the Commission's govern, and it was placed there mainly so that you could refer it back to the paragraph concerned.

2-(b) Methods of Improving and Existing Health Services
Patient care in active treatment.

General hospitals is becoming more costly each year. Costs in a university-affiliated hospital are consistently higher than in a non-affiliated hospital. It is therefore

1 - That new-type facilities which have been proven to reduce costs of care be approved under the Federal-provisional agreement: e.g., self-care units, day hospital and night hospital facilities.

2 - That diagnostic out-patient services be approved as a benefit under the hospital insurance plan.

2-(c) The Corporation of a new and improved Program which Services with a View to Providing Improved Health Services.



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4 Because of their teaching and research
5 programs, university hospitals must provide a most compre-
6 hensive diagnostic and treatment service. Unnecessary
7 duplication of costly and specialized personnel and
8 equipment reduces the scope of the program and adds
9 unjustifiable costs to government plans. It is recommen-
10 ded:

11 1 - That university-affiliated, teaching
12 hospitals be considered as special
13 referral units and that special services
14 be centred in such hospitals.

15 D-(d) & (e) The Provision of Adequate Numbers of Personnel
16 with the Best Possible Training and Qualifica-
17 tions for Health Services.

18 A university hospital is closely affi-
19 liated with the teaching personnel and facilities of the
20 university. The training of the increasing numbers of
21 personnel required by our expanding health services is
22 taxing the capacity of hospitals and universities. A
23 more efficient educational scheme would result from the
24 avoidance of duplication in the teaching of basic science
25 courses, and the concentration of clinical teaching in
26 the hospital. It is recommended:

27 1 - That the educational facilities of
28 the university be used to provide the
29 basic science teaching of health service
30 personnel; and that clinical instruction
be concentrated in the hospital.

2 - That where the education of certain
health service personnel does not require



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3 teaching at the university level,
4 the facilities of a vocational training
5 school or college be used, with the
6 clinical instruction given at a hospi-
7 tal.

8 (f) & (g) No recommendations.

9 (h) & (i) No recommendations.

10 E-(j) The Relationship of Existing and Any Recommended
11 Health-Care Programs with Medical Research and the
12 Means of Encouraging a High Rate of Scientific
13 Development in the Field of Medicine in Canada.

14 The improvement of health-care programs
15 in Canada depends on medical research. A large percen-
16 tage of the clinical research in this country is carried
17 out in university-affiliated, teaching hospitals. A
18 high rate of scientific development in the field of medi-
19 cine in Canada can only result from the provision of ade-
20 quate funds to encourage an expansion of costly research
21 facilities in such hospitals. It is recommended:

22 1 - That the increased patient-day cost
23 of care in university hospitals be
24 recognized and paid.

25 2 - That government funds be made
26 available for the increased capital,
27 equipment, and operating costs which
28 will result from an intensive clinical
29 research program.

30 3 - That increased funds be made avail-
able to encourage more qualified person-
nel to engage in research.

teaching at the university level,
the facilities of a vocational training

(c) 3 (g) No recommendations.

(c) 3 (h) No recommendations.

3-(j) The relationship of existing and new research

Health-Care Research with Medical Research and the
Fields of Interest

Development in the Field of Health in Canada

The improvement of health-care programs
in Canada depends on medical research. A large percentage
of the health research in this country is carried
out in university-affiliated, teaching hospitals. A
high rate of scientific development in the field of medicine
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funds to encourage an expansion of costly research
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of care in university hospitals be
recognized and paid.

2 - That government funds be made
available for the increased capital,
equipment, and operating costs which
will result from an intensive clinical
research program.

3 - That increased funds be made available
to encourage more qualified personnel
to engage in research.



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4 Mr. Chairman and members of the
5 Commission, the group that is here with me today is
6 prepared to answer any inquiries you may have on the
7 operation of the hospital or the problems that confront
8 it at the present.

9 THE CHAIRMAN: Thank you very much,
10 Dr. Wallace.

11 We heard from the Honorable Minister of
12 Health regarding hospital budgets. Is there anything
13 unique about the University Hospital's budget as distinct
14 from the other hospitals? The other general hospitals?

15 DR. WALLACE: No, sir, there is not.
16 The University Hospital is treated as is any other hospi-
17 tal.

18 THE CHAIRMAN: And you come under this
19 rated bed-day business?

20 DR. WALLACE: Yes, sir.

21 THE CHAIRMAN: And what happens if you
22 have a deficit at the end of the year?

23 DR. WALLACE: This, sir, is a very big
24 problem in that we are operated under the Board that is
25 responsible to the Lieutenant-Governor in Council. We
26 therefore do not have a municipality or a city to go to
27 for unapproved costs. We have been in the fortunate
28 position every other year until last year of not having
29 unapproved costs, but the inclusion of a large clinical
30 service wing as part of our institution has resulted in
a rather rapid increase in utilization and costs, and
therefore as of 1961's operating picture I presume we
will have to go to the Lieutenant-Governor in Council in



Mr. Chairman and members of the

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services which as part of our institution has resulted in a rather rapid increase in utilization and costs, and

therefore as far as the operating picture I presume we will have to go to the Lieutenant-Governor in Council in



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3 an attempt to obtain whatever funds we need to meet our
4 deficit.

5 THE CHAIRMAN: There is no other place
6 to go?

7 DR. WALLACE: We have no other place.

8 COMMISSIONER VAN WART: Does the
9 Department of Health make a special ceiling for your
10 hospital?

11 DR. WALLACE: No, sir, it does not,
12 because on past operation we have actually been operating
13 under the absolute ceiling, including last year.

14 COMMISSIONER VAN WART: That is the
15 ceiling for general hospitals, small hospitals, or any
16 hospitals?

17 DR. WALLACE: That is the ceiling for
18 the large 180 and over hospital group.

19 THE CHAIRMAN: Well, we understand
20 there is a maximum ceiling, but no fixed ceiling? I
21 mean, a ceiling applies to individual hospitals?

22 DR. WALLACE: Individual hospitals,
23 but there is a maximum.

24 THE CHAIRMAN: I take it you are opera-
25 ting on the maximum \$12.72?

26 MR. SHERWOOD: In 1961 our rated bed-day
27 cost was \$12.32, 1/2 a day.

28 THE CHAIRMAN: Thank you.

29 DR. WALLACE: The Department of Public
30 Health announced a 3% increase allowed in 1961, which
would be added to that rated bed-day payment.

THE CHAIRMAN: Applicable retroactively



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THE CHAIRMAN: There is no other place.

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DR. WALLACE: We have no other place.

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Department of Health want a special ceiling for your

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DR. WALLACE: That is the ceiling for

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and there is a maximum.

THE CHAIRMAN: I take it you are saying

that on the maximum \$12.00?

MR. STEWART: In 1961, our fixed bed-day

cost was \$12.32, 32 cents a day.

DR. WALLACE: The Department of Public

Health announced a 10 percent increase allowed in 1961, which

would be added to that fixed bed-day payment.

THE CHAIRMAN: Applicable retroactively



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3 throughout 1961?

4 DR. WALLACE: Throughout 1961; yes,
5 sir.

6 MR. SHERWOOD: I am sorry, sir, I am
7 going to have to blush. The figures I gave you were
8 for 1960.

9 THE CHAIRMAN: That is all right. I
10 suppose it is too soon to have arrived at the 1961
11 figures?

12 MR. SHERWOOD: I have a fairly good
13 idea what it will be, and it will be, I believe, \$13.32.

14 THE CHAIRMAN: Including the 3%?

15 MR. SHERWOOD: This is the total cost.
16 Applying the 3% on our last year's cost, our 1960 costs,
17 it will be \$12.59, which is what we have received, but
18 our actual cost will call for a rated bed-day payment of
19 \$13.32.

20 THE CHAIRMAN: And that is how the
21 deficit will arise between \$12.59 and \$13.32?

22 MR. SHERWOOD: That is right.

23 COMMISSIONER VAN WART: In 1962, the
24 ceiling will be based on the figures you give us now?

25 THE CHAIRMAN: Who foretells the future!

26 DR. WALLACE: The problem is, sir, that
27 we will not know what the actual 1962 allowance is until
28 some time in 1963 after we have made all our expenditures.

29 THE CHAIRMAN: How does that operate,
30 actually, in a matter of efficient operation, as a busi-
nesslike operation, to go through a whole year and not
know the amount of money you are going to get? The



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exact amount of money you are going to get.

DR. WALLACE: May I refer that to our business manager?

MR. SHERWOOD: This is beyond a doubt one of the difficulties of our plan. The principle is laid down in the regulations with the Government that at the end of the year any hospital may submit their financial statement to the Department and providing they can justify an increase in their costs, this increase will be paid out of a special appropriation.

THE CHAIRMAN: Justified to whom?

MR. SHERWOOD: If I may refer to the particular section; the section reads as follows:

"A review of the audited costs of each approved hospital shall be made as at the 31st of December of each year and where increases over the basic monthly payments can be supported by reasonable evidence a retroactive adjustment of the payments made on account shall be granted by a supplementary payment under ministerial order".

This would be made to the Director - the application would be made to the Director of the Hospital Plan.

THE CHAIRMAN: And depending on the Director's judgment you get the result?

MR. SHERWOOD: That is right.

THE CHAIRMAN: Is there not an appeal provision from the Director?

exact amount of money you are going to get.

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MR. SHERWOOD: This is beyond a doubt.

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MR. SHERWOOD: Not a satisfactory one.

THE CHAIRMAN: What I mean is, is there one set up by the regulations?

MR. SHERWOOD: No, there is not.

THE CHAIRMAN: So you finally come up against the judgment of one man. Are you operating an out-patient department at the Alberta University Hospital?

MR. SHERWOOD: Yes sir, we are.

THE CHAIRMAN: To what extent?

MR. SHERWOOD: Our out-patient department is on a dollar cost basis. Our costs in 1961 to operate this department, including the drugs that were provided, were \$60,000.

DR. WALLACE: Dr. Snell, I think, could answer this.

DR. SNELL: The total number of patients of indigent out-patients to visit the out-patient department in 1961 was just in excess of 18,000. The out-patient department opened in the hospital in September of 1960. Before this time and for a number of years previously it had operated in a building in the centre of Edmonton some three or four miles from the hospital and was budgeted for by the hospital in 1960. The number of patients attending the out-patient department has greatly increased over the years and has continued to increase although the out-patient department is no longer in the centre of population.

COMMISSIONER BALTZAN: These 18,000 visits, are they new patients or are they also including revisits of the same patients?



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DR. SNELL: Total visits including revisits.

COMMISSIONER BALTZAN: Have you a breakdown of new patients?

DR. SNELL: I do not have that with me.

THE CHAIRMAN: Is the out-patient service available to all or to one particular class or classes?

DR. SNELL: The out-patient department is really divided into two parts; there are a number of special services of special clinics. These special clinics are not included in the 18,000 visits. If they were all included it would come to about 25,000. They are available to anyone to whom that particular special clinic is applicable.

THE CHAIRMAN: Such as?

DR. SNELL: The glaucoma clinic, anyone who is referred to the glaucoma diagnostic clinic by his physician is handled by that clinic irrespective of his financial position. However, the 18,000 that I referred to earlier are patients who are indigent. Not only indigent patients are accepted in the clinic.

THE CHAIRMAN: Who diagnoses the class; say individual X goes to the clinic today, the out-patient clinic?

DR. SNELL: The designation is carried out by the admitting officers of the clinic who assesses the patients' financial status on the first visit.

THE CHAIRMAN: Do you find that is satisfactory, that it works out satisfactorily?

visits.

COMMISSIONER BALZAN: Have you a

breakdown of new patients?

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who is referred to the glanders diagnostic clinic by his

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DR. SNELL: Yes, sir.

THE CHAIRMAN: What is the attitude of the individual patient to being questioned and having his needs so assessed?

DR. SNELL: I do not feel the individual patient objects strongly to this. Occasionally there are patients who do object but the vast majority do not bother to do so.

THE CHAIRMAN: They appear to accept it?

DR. SNELL: Yes.

THE CHAIRMAN: Now, there are occasions when a person may go to the out-patient clinic and on the assessment being made is informed that he is not eligible?

DR. SNELL: There are, yes. In these circumstances a patient will be seen on his first visit but he will be directed to a private physician for subsequent treatment.

THE CHAIRMAN: He will not be turned away?

DR. SNELL: No.

THE CHAIRMAN: But he will be told he is able to look after himself and put into the normal channels for treatment?

DR. SNELL: That is right.

COMMISSIONER BALTZAN: Except for emergencies, are these people referred patients by their family physicians or out-of-town physicians or can one go of his own choice to the outdoor?

DR. SNELL: The patients can come ---

THE CHAIRMAN: What is the attitude of the individual patient to being questioned and having his needs so assessed?

DR. SMULL: I do not feel the individual patient objects strongly to this. Occasionally there are patients who do object but the vast majority do not bother to do so.

THE CHAIRMAN: They appear to accept it?

THE CHAIRMAN: Now, there are occasions when a person may go to the out-patient clinic and on the assessment being made is informed that he is not eligible. DR. SMULL: There are, yes. In these circumstances a patient will be seen on his first visit but he will be directed to a private physician for assessment.

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DR. SMULL: That is right.

And these people referred patients by their family physicians or out-of-town physicians or can go of his own choice to the surgeon?

DR. SMULL: The patients can come



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THE CHAIRMAN: Dr. Baltzan insists we get these people outdoors and I do not think that is right.

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DR. SNELL: This is a term that has been used for this clinic and I think Dr. Baltzan is quite right for using this term.

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THE CHAIRMAN: We laymen have a different view.

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DR. SNELL: The patients can refer themselves to the indigent clinic but the special clinics will only accept them on referral by a physician.

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THE CHAIRMAN: Who, if anyone, pays for this or will pay for these 18,000 visits of the indigent patients to the out-patient clinic?

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MR. SHERWOOD: Under the present arrangement the cost of a particular out-patient clinic is not shareable under the Federal-Provincial plan.

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THE CHAIRMAN: Do you say that by virtue of the regulations?

19

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MR. SHERWOOD: That is my understanding that the cost of an out-patient department is not shareable. However, the Provincial Government here has taken the responsibility of reimbursing us for the cost of operating this clinic which is paid to us on a direct cost basis.

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THE CHAIRMAN: That is additional to your rated ---

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MR. SHERWOOD: That is right. This cost is withdrawn from our normal operating costs.

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COMMISSIONER BALTZAN: But you do get

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get these people outdoors and I do not think that is

DR. SWELL: This is a term that has

quite right for using this term.

THE CHAIRMAN: We laymen have a differ-

DR. SWELL: The patients can refer the

selves to the indigent clinic but the special clinics

will only accept them on referral by a physician.

THE CHAIRMAN: Who, if anyone, pays

for this or will pay for these 15,000 shares of the insti-

tute patients to the out-patient clinic?

MR. STEPHENSON: Under the present arrangement

the cost of a particular out-patient clinic is not

absorbable under the Federal-Provincial plan.

THE CHAIRMAN: Do you say that by

virtue of the regulations?

MR. STEPHENSON: That is my understanding

that the cost of an out-patient department is not shared

between, however, the Provincial Government, have been taken

the responsibility of reimbursing us for the cost of

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cost basis.

THE CHAIRMAN: That is additional to

your rates --

MR. STEPHENSON: That is right. This

cost is withdrawn from our normal operating costs.

COMMISSIONER BATTAN: But you do get



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3 paid for x-ray and laboratory costs for these patients,
4 or do you, under the Diagnostic Services Act?

5 MR. SHERWOOD: Diagnostic services are
6 not charged against the operations of the clinic and so
7 consequently they appear in the operational picture of
8 the hospital; the cost operation picture of the hospital.
9 However, again, the Department has a formula for paying
10 bad debts and they have agreed that these accounts for
11 services provided by other departments in the hospital
12 other than out-patient clinics, those from the out-patient
13 department, those will be immediately acceptable under
14 their bad debt formula, and therefore, we do not feel
15 the account is paid by the Government.

16 COMMISSIONER BALTZAN: In other words,
17 you do not get any relief by the new Act, the so-called
18 Hospital Diagnostic Services Act?

19 DR. WALLACE: If I may elaborate on
20 that?

21 THE CHAIRMAN: I am going to suggest to
22 you you are not correctly informed on the position from
23 Ottawa.

24 DR. WALLACE: The correction on that
25 would be that until such time as Alberta as a province
26 agrees to provide out-patient services ---

27 THE CHAIRMAN: If the province makes
28 itself pay for the out-patient services Ottawa will
29 cover the other half.

30 DR. WALLACE: At the present time ---

THE CHAIRMAN: If Alberta chose to do
it the money is available because we know other provinces

paid for x-ray and laboratory costs for these patients,

on to you, under the diagnostic services Act?

MR. SHIRWOOD: Diagnostic services are

not charged against the operations of the clinic and so

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it will pay for the out-patient services Ottawa will

MR. WALLACE: At the present time ---

THE CHAIRMAN: If Alberta chose to do

it the money is available because we know other provinces



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3 are doing it - Manitoba is one.

4 COMMISSIONER McCUTCHEON: How do you
5 pay your bills during the year if you are running
6 steadily over, where do you get your overdraft?

7 MR. SHERWOOD: As far as the University
8 Hospital is concerned we, like all other hospitals,
9 receive on a monthly basis, one-twelfth of the amount of
10 money, the total amount of money that the Government paid
11 us in the previous year. This comes to us automatically
12 each month and those are the funds that we use. Now,
13 under the plan, the initiation of the plan, hospitals
14 were allowed to retain their accounts receivable and any
15 prepaid plan assets. In that way all money that they had,
16 and the expectation of the plan was, that the hospitals
17 would use those funds as their operating capital. Some
18 hospitals have been in an operating position in this
19 respect and others have not been quite so fortunate.

2 THE CHAIRMAN: Has that been continued
or has that practice been changed?

20 MR. SHERWOOD: It is still continuing.
21 There is no provision made for operating capital.

22 THE CHAIRMAN: Perhaps I am not correctly
23 informed but I put it to you that that is so, that
24 hospitals that had an accumulation of accounts receivable
25 and which they did receive subsequently, they had to use
26 that money, have been required to use it for capital
expenses in building.

27 MR. SHERWOOD: Yes.

28 THE CHAIRMAN: So that it is not
29 available, there must have been a change some place
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3 along the line?

4 DR. WALLACE: In our case we might say
5 we have not as yet had a capital construction program
6 that might have completely depleted our reserve.

7 COMMISSIONER McCUTCHEON: If I under-
8 stand what you are saying it is that in the year in which
9 you have a deficit like last year and where the amount
10 you received in 1960 and where you obviously over-spent
11 considerably, you simply take in this whole working
12 capital fund because you have not used it to put up a
13 building but when you go to put up a building it won't
be there.

14 DR. WALLACE: Right, sir.

15 THE CHAIRMAN: And if you have not that
16 fund what do you do? Do you borrow from the bank?

17 MR. SHERWOOD: That is correct. The
18 hospital that would have the major problem is the new
19 hospital that has agreed to the plan.

20 THE CHAIRMAN: It had a building program
21 that ate up the reserves which were required to eat up
the reserves.

22 MR. SHERWOOD: I think, sir, that the
23 Department expects hospitals or will allow a hospital to
24 retain a sufficient amount of their pre-plan assets to
25 provide an adequate working capital for them.

26 THE CHAIRMAN: I think perhaps we will
27 follow this with the Associated Hospitals when that brief
28 comes. You have not had that problem because of your
29 particular situation. If you make a profit in a year -
30 is it conceivable that a hospital in Alberta can make a



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3 profit?

4 MR. SHERWOOD: No sir, there is no
5 profit to be made under the present plan.

6 THE CHAIRMAN: Supposing there is a
7 surplus at the end of a given year?

8 MR. SHERWOOD: There cannot be a
9 surplus because the plan, this very basic ceiling is
10 the amount of expense incurred, payment of the amount of
11 expense incurred.

12 THE CHAIRMAN: Does it follow that
13 there is no provision by which a reserve can be accumu-
14 lated for any period?

15 MR. SHERWOOD: No, sir.

16 THE CHAIRMAN: And in a hospital that,
17 say, was in existence and had its plant at the start of
18 the program, did it receive anything for the value of
19 the plant that has been put at the disposal of the plan?

20 MR. SHERWOOD: No sir, the ownership
21 of the plant is retained by the operators of the hospital.

22 THE CHAIRMAN: But do they get anything
23 for it?

24 MR. SHERWOOD: No sir, other than ---

25 THE CHAIRMAN: Other than the opportunity
26 to not make a profit but the possibility of having a
27 deficit?

28 MR. SHERWOOD: That is right.

29 THE CHAIRMAN: We are trying to find
30 out what is going on in Canada.

MR. SHERWOOD: Mr. Chairman, I might
add one further bit of information to it that new



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3 construction, approved new construction, is paid for in
4 two manners; the Provincial Government, if the new
5 construction represents an amount of less than \$100,000,
6 they could approve it and agree to repay the hospital
7 for the expense as the expense is incurred. In other
8 words, the hospital pays the expense but claims it back
9 and is paid in cash or the hospital may have amounts in
10 excess of \$100,000 financed, the building and the plant
will pay the debenture payments.

11 THE CHAIRMAN: Of principal and interest?

12 MR. SHERWOOD: Principal and interest.
13 The interest rate is limited to the rates being paid by
14 the municipal finance corporation.

15 THE CHAIRMAN: To get the money in the
16 market they have to pay a higher rate of interest?

17 MR. SHERWOOD: They must assume the
responsibility for paying it.

18 THE CHAIRMAN: The hospital must and
19 could that be carried into the budget anywhere?

20 MR. SHERWOOD: No, sir. Interest rates
21 are not recognized either by the hospital that must borrow
22 for operating capital, they are not recognized as an
23 approved expense.

24 THE CHAIRMAN: So if a hospital, in the
25 course of a year to pay its weekly or semi-weekly or
26 monthly wage bills, has to go to the bank for money, that
interest charge is not an operating charge?

27 MR. SHERWOOD: That is correct.

28 THE CHAIRMAN: Where does that money
29 come from to pay that interest? We must act on the basis



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3 that the banks will get the interest.

4 MR. SHERWOOD: It would depend on the
5 type of hospital that is involved; if it is a municipal
6 hospital this type of expense is regarded as unapproved
7 expense and the Act provides that the hospital may make
8 a warrant against the municipality for the additional
9 expense that they incur. It is not an approved expense.
10 The voluntary hospitals have a definite problem in this
11 regard and I do not know just how some of them are
12 solving it.

13 THE CHAIRMAN: Mr. Sherwood, we have
14 the word "approved expenses". Is that defined by
15 statute or regulation or by the judgment of an individual?

16 MR. SHERWOOD: Well, again, it depends
17 on the nature of the expense and the ceiling.

18 THE CHAIRMAN: Has the Legislature said
19 that interest on money charged for operating expense is
20 not an approved expense?

21 MR. SHERWOOD: It has not been stated
22 to my knowledge.

23 THE CHAIRMAN: The Legislature has not
24 said it. Has the regulation been approved and formulated
25 by the Lieutenant-Governor in Council?

26 MR. SHERWOOD: I am sure it is not in
27 our regulations at all, sir.

28 THE CHAIRMAN: Now then, it becomes a
29 matter of some administrator's judgment.

30 MR. SHERWOOD: That is right.

THE CHAIRMAN: In the one-man operation.

MR. SHERWOOD: There is a Director of



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3 the plan who has officers under him and has advisors.

4 THE CHAIRMAN: But the Director, he
5 is a sole director?

6 MR. SHERWOOD: Responsible to the
7 Minister, sir.

8 COMMISSIONER McCUTCHEON: I was looking
9 at your Act to consolidate and revise the law relating
10 to hospitals and hospitalization and that Act is the
11 Act, the second part of it sets out, Part III sets out,
12 the hospitalization benefit plan. It defines the
13 general hospital, or a hospital as an institution opera-
14 ting for the care of diseased, injured and sick people
15 and then the definition of a general hospital is somewhat
16 expanded and I come to your Board Act. Your Board shall,
17 among other things, administer the hospital for the care
18 and treatment of the sick. That is what a hospital is
19 defined as doing. Then it goes on to say you are to
20 "provide educational facilities to students of medicine,
21 surgery, nursing and kindred matters". You are to employ
22 the necessary medical, surgical and pharmaceutical officers,
23 nurses, attendants, and clerical staff for the proper opera-
24 tion of a teaching and treatment hospital. In other
25 words, your Board is liable to do a great many things a
26 hospital is not required to do under the Alberta Hospital
27 Act and for which it is not paid under the Alberta
28 Hospital Act.

26 I come now to you; the business admini-
27 strator shall "expend the monies of the hospital on
28 behalf of the Board in accordance with the budget approved
29 by the Provincial Treasurer". Surely this contemplates
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your teaching and research requirements are in quite a different position than a hospital under the Act. It would have a budget approved by the Provincial Treasurer.

DR. WALLACE: It is not so done in practice.

COMMISSIONER McCUTCHEON: There is not, but you are telling me the practice.

MR. SHERWOOD: Since the plan came in it was indicated the University Hospital would operate in and under the plan.

THE CHAIRMAN: Who said that?

MR. SHERWOOD: Well...

THE CHAIRMAN: Did the Legislature say it? Did the Lieutenant-Governor in Council say it? Did the Minister say it or did the administrator say it?

MR. SHERWOOD: I think, sir, that it is stated "in that all approved hospitals are to operate under..."

THE CHAIRMAN: Who states that? Do you read it on the wall?

MR. SHERWOOD: The Minister, sir.

THE CHAIRMAN: You say, in the recommendations that you make to us, you ask that governmental hospitals, government hospital plans recognize the special role of the University affiliate hospital and meet costs of patient care and special services and patient-centred research field as set out in your Act.

If they are already covered by Statute what do you want this Commission to do?

DR. WALLACE: I don't know whether there is anything the Commission from the federal level



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3 can do. It is, I believe, a provincial matter. The
4 organization of the hospitalization plan in the particular
5 province. The hope has been that at some time, either
6 federally or provincially, that education as it concerns
7 hospitals would be a special type of education rather
8 than part of the general operation of the patient care
9 areas of a hospital in order that budgeting could be
10 done for schools of nursing in the various other schools
11 we have.

12 These might not necessarily be part of
13 the general plan for operating hospital care.

14 THE CHAIRMAN: Schools of nursing; do
15 you get a special budget for the hospital which operates
16 schools of nursing?

17 DR. WALLACE: No sir.

18 THE CHAIRMAN: It must come back then
19 to this rated bed business?

20 DR. WALLACE: Right, sir.

21 THE CHAIRMAN: Even in University
22 hospitals?

23 DR. WALLACE: Yes sir.

24 THE CHAIRMAN: In the operation of a
25 nursing school, within the framework of your organization,
26 do you allot a budget to the nursing school?

27 MR. SHERWOOD: There is a budget pre-
28 pared on the basis of an estimate of the expenses of the
29 nursing school, yes. There is not a revenue allotment
30 related to the nursing school.

THE CHAIRMAN: We have had requests,
recommendations of a nursing organization in every



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3 province that we have been in to get, and that is one
4 of the propositions that they came forward with, a budget
5 for the nursing school, an independent budget for the
6 nursing school.

7 MR. SHERWOOD: Do you mean a budget
8 that shows an expense side and a revenue side?

9 THE CHAIRMAN: That is what a budget
10 would have to be.

11 MR. SHERWOOD: Their budget is within
12 the hospital's budget. There is no special revenue
13 credited to the nursing school.

14 THE CHAIRMAN: If the hospital's
15 expense are running a little higher than anticipated
16 they can chisel the nursing school?

17 MR. SHERWOOD: It hasn't been necessary.

18 THE CHAIRMAN: Or vice versa, if a
19 nursing school budget is running too high you will starve
20 the amount allocated to the hospital. Is that the way it
21 works in practice?

22 MR. SHERWOOD: Yes, that is the danger
23 of our system, sir.

24 THE CHAIRMAN: This system is one that
25 focuses the control initially on the administrator but
26 ultimately on the Minister.

27 COMMISSIONER VAN WART: In obtaining
28 new equipment when it is necessary, say, an expensive
29 article of equipment, do you have any difficulty in
30 obtaining those under the present system?

MR. SHERWOOD: The present system, sir,
is that the Government has established a provision of



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3 \$100 per bed per annum for the provision of equipment.
4 With the University Hospital just for the year to year
5 operation of the hospital, if the hospital builds an
6 addition or an extension to their plant, then a special
7 provision would also be recognized for the equipment
8 that might initially be required. This \$100 a bed
9 applies only to the equipment the hospital normally
10 requires in its year to year operation. The University
11 Hospital has not as yet had difficulty in this respect.
12 We have come up to the ceiling of the monies provided
13 to us, but it has lasted us pretty well through the year
14 and our relationship with the Department, the University
15 Hospital's relationship with the Department in this
16 respect I would have to classify as quite satisfactory.

16 COMMISSIONER VAN WART: The teaching
17 research hospital would need more expensive equipment
18 than an ordinary hospital. Is that not so?

18 MR. SHERWOOD: Yes sir, research equip-
19 ment.

20 COMMISSIONER VAN WART: But there is
21 no provision made for that difference?

22 MR. SHERWOOD: Research equipment is
23 purchased, a substantial amount of it is procurable from
24 M.R.C. grants and public health grants and some other
25 sources, voluntary sources, are available to the hospital
26 for the purchase of special research equipment such as
27 the Polio Foundation and the Arthritis Association and
28 so on; they will provide money for this equipment if it
29 is relatable to their particular interests and the
30 hospital's pre-plan resources make provision for some,



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3 the purchase of some equipment in this area.

4 COMMISSIONER VAN WART: Outside of the
5 research, if you need it for the ordinary running of the
6 hospital, say, a tomogram for the x-ray department or something
7 you are receiving adequate funds to purchase all the
8 equipment that you require?

9 MR. SHERWOOD: To date, yes. We wonder,
10 when the day arrives when we may have to replace a \$30,000
11 or \$40,000 piece of equipment, this may make quite a hole
12 in our allotment for that particular year.

13 COMMISSIONER VAN WART: You anticipate
14 in a few years, being a new hospital, your equipment will
15 depreciate and will have to be replaced. Do you anticipate
16 difficulties in replacing all the equipment under the
17 present scheme?

18 MR. SHERWOOD: I cannot, at the moment,
19 give you a qualified answer on this.

20 THE CHAIRMAN: Mr. Sherwood, I want to
21 go back to page 5, the last line under Item 4. You ask
22 that regulations under the Hospital Insurance and Diagno-
23 stic Services Act be amended to allow special revenue
24 mechanisms to be used in hospitals in which government
25 payments do not provide adequate funds for good standards
26 of patient care together with education and research
27 programs and hospital services. Just what are you
28 asking for?

29 DR. WALLACE: May I answer, sir?

30 THE CHAIRMAN: Yes.

DR. WALLACE: The idea was that obviously
hospitals cannot operate indefinitely on a deficit every

I have equipment in this area.

COMMISSIONER: MAY I?

Thereafter, if you need it for the ordinary running of
hospital, say, a program for the x-ray department or
you are receiving other services.

equipment that you need?

MR. SHAW: To date, yes. We

on \$42,000 piece of equipment, this may take place in
in an allocation for that particular year.

COMMISSIONER: A year. The allocation

for a few years, to have a new hospital, your statement will
of the equipment that is required for you in the

of the equipment.

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4 year. It is our feeling, and I think the feeling of most
5 hospitals, that if the Government sources are not going
6 to provide adequate funds to provide hospitalization
7 that the hospitals should be allowed some mechanism by
8 which they could charge people using the facilities.

9 THE CHAIRMAN: This would be an addi-
10 tional charge against the patient making use of the
11 services?

12 DR. WALLACE: Right; which is contrary
13 to the whole thinking of the plan.

14 THE CHAIRMAN: Do you recommend that?
15 Do you put that forward as a recommendation which you
16 want this Commission to support?

17 DR. WALLACE: Morally, sir, I wouldn't
18 recommend it, but if it came to a position of being unable
19 to provide quality services, or to provide services
20 without reducing the present quality, I feel the hospital
21 should attempt to maintain the quality, at least, at the
22 present level and it would be by compensation.

23 THE CHAIRMAN: Even if you have to go
24 out and pass the hat to get money?

25 DR. WALLACE: Yes.

26 COMMISSIONER McCUTCHEON: The Act does
27 permit any person who wants to pay his hospital bill and
28 not take advantage of the Act to do so. You feel you
29 might get some people to do that?

30 DR. WALLACE: At the present time it
would be considered as offset revenue and wouldn't really
provide us any extra funds.

THE CHAIRMAN: It would have to go



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direct to the Government pot?

DR. WALLACE: Yes.

THE CHAIRMAN: What about donations, voluntary donations, suppose someone came along and gave you a thousand dollars or ten thousand dollars?

DR. WALLACE: It would have to be earmarked, sir, for something outside the routine operation of the hospital. It could go into a foundation.

THE CHAIRMAN: Just a donation, somebody coming along and saying, "I have been well treated here, I would like to just make a donation to the hospital".

DR. WALLACE: If we couldn't stipulate some special place it would go it would be put into the pot.

THE CHAIRMAN: To the Government credit.

I want to move, Dr. Wallace, if I may, to my letter to you of December 19th. I am grateful to you for your correspondence, your response to it, and for arranging that representatives of the other three hospitals would be here this morning, that is representatives from the Edmonton General Hospital and the Misericordia Hospital and the Royal Alexandra Hospital. The matters that we were interested in receiving, which I wrote to you on December 19th about, deal with day-to-day operations of the hospital in terms of hospitalization and possible over-utilization and so forth. I take it you have made some studies and that the other hospitals have made studies. Perhaps the representatives from the other hospitals might come forward.

DR. WALLACE: Might we change teams?



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THE CHAIRMAN: No, perhaps they would join you. I didn't know how many there were, but I am sure we can find places.

DR. WALLACE: If I might introduce the others to you; Mr. Russell C. Nye, Executive Director of the Royal Alexandra Hospital; Dr. Learmonth, who is Assistant Director of Medical; Dr. Macdonald, who is Medical Superintendent of Misericordia Hospital; Sister St. Guy, the Superior; Sister Bergeron from the General Hospital; Dr. Clare, the Medical Director of the General Hospital.

As a result of our one-day study on utilization we haven't prepared a brief, but we have placed numerous statistics on this paper. Would it be in order to put it in?

THE CHAIRMAN: Yes, if you will.

DR. WALLACE: I am sorry we couldn't hand them to you before so you could study them.

THE CHAIRMAN: We will make this Exhibit 121.

--- EXHIBIT NO. 121: Bed Utilization Survey, City of Edmonton.

DR. WALLACE: Would it be in order to leave it to you to direct questions to any of the other hospitals?

THE CHAIRMAN: Did you have some sort of a general or preliminary statement you wanted to make as to this question of utilization of hospital facilities?



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4 DR. WALLACE: In brief, I might point
5 out that the group that is represented here has formed
6 an organization of the Edmonton hospitals known as the
7 Edmonton Advisory Council. Representatives from this
8 Council meet each month, or more frequently if necessary,
9 to discuss the mutual problems of the situation in an
10 attempt to maintain a close relationship between the
11 facilities that we have.

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When the request came to each hospital
to have a representative present to discuss matters of
utilization, we held a meeting and decided to get
the information for ourselves, in order that we could
probably answer the questions. It would be of advantage
to see what the exact situation was in our city hospitals.
Therefore, on the 17th of January, 1962, starting first
thing in the morning-- between 8 and 9 o'clock-- physi-
cians on the medical staff of the hospitals were requested
to survey all patients in all of the hospitals and to
survey them on the basis, with the supposition that there
were other facilities to which patients might be sent,
that there are lots of nursing homes and chronic hospi-
tals and these various things. Therefore, I do not feel
that the figures on this paper necessarily represent a
number of people who are in the hospital that should not
be there.

THE CHAIRMAN: No, we appreciate that.

DR. WALLACE: At the present time, I
am just hoping the press will pick that up.

THE CHAIRMAN: You are assuming a
perhaps more ideal situation?



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DR. WALLACE: Right, sir.

THE CHAIRMAN: And this would be the result?

DR. WALLACE: Assuming, too, that the active treatment hospital probably costs up to \$25 a day for a bed and the other facilities would probably not be as costly.

COMMISSIONER BALTZAN: Would you say just how much less, actually?

DR. WALLACE: The statistics we have at the moment would indicate that the chronic hospital is not as cheap as most people think, if it is properly operated, but it would be slightly less costly because of the utilization of active treatment hospital special services, such as radiology and these other factors, and the fact that there is no surgery carried out.

COMMISSIONER BALTZAN: Would it be three-quarters?

DR. WALLACE: Three-quarters would be a reasonable estimate. We have had information from areas where they have self-care units that any such unit's construction costs and operating costs are about 50% of the active treatment.

THE CHAIRMAN: Well, now, we are going to try to keep on the rails in relation to the matters that we are concerned with here, because a question of costs is another story.

DR. WALLACE: Right, sir.

The survey was done and as a result of the survey these statistics were prepared.



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THE CHAIRMAN: In the fourth line, you say "Using the forms and covering letters attached to this report".

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DR. WALLACE: I am sorry, sir. I thought you would notice that.

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THE CHAIRMAN: They do not appear to be attached. May we have them at your convenience?

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DR. WALLACE: Right, sir.

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THE CHAIRMAN: I do not want them now, but we need them when our research people deal with it so they may have the full story.

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DR. WALLACE: Right, sir, we will see that you have it.

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And the information, then, I think, is available to you. The totals were interesting enough. Of 2,395 beds, there were 2,242 occupied on that particular day, and in those beds were 501 patients that the physicians themselves felt should not be there if they had somewhere else to go.

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THE CHAIRMAN: Because there were not these other facilities?

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DR. WALLACE: They are occupying beds. The other significant figure is that there is a waiting list. The total reported from all hospitals; 3,000 on waiting lists, many of them children waiting for T & A's. But if those 501 patients were not there, there would be no problem in Edmonton with active treatment beds.

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THE CHAIRMAN: And I would like, on behalf of the Commission, to extend our thanks to you and to the administrators of the other hospitals for



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3 having made this survey because these figures are neces-
4 sarily the only kind of figures that are authoritative.
5 I mean, everything else is guessing, and we know that
6 when we make these requests we are imposing a burden on
7 hospitals, and we are most grateful for the hospitals
8 having assumed that burden and given the information.

9 Now, that is the question on the 17th
10 of January in the matter of admissions.

11 Dr. Wallace, are you able to give us
12 any information on how the question of admission is
13 dealt with so as to deal with or to ensure that only
14 those entitled to be admitted are admitted?

15 We have had it said to us that because
16 diagnostic costs -- x-ray and diagnostic services -- are
17 not shared costs, these out-patient costs are not shared
18 costs, that physicians take patients into hospitals to
19 have diagnostic and x-ray work done that could be done
20 in the out-patient department.

21 DR. WALLACE: May I pass that question
22 on to Dr. Macdonald of the Misericordia Hospital?

23 THE CHAIRMAN: Yes.

24 DR. MACDONALD: Mr. Chairman, there
25 are two points in the policy of admission which we
26 attempt to follow, and the first one is that any true
27 emergent case must receive attention and admission. We
28 do not argue or question this problem, whether it would
29 involve putting up a bed in the hall or what.

30 This is the first point. The emergent
case has no obstacle in its way.

The second group of cases that are



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admitted are those which we determine elective cases. We have a priority system of sorts, in which in the elective or non-urgent case, preference is given in fact to those physicians who are on our attending or active staff.

The determination of the necessity of a patient being in the hospital, particularly in the elective group, is one which is carried out on a personal basis between the administrative people and the physician in charge of the case.

If it appears -- and we have access daily to statistics regarding the condition or the length of time that a patient has been in the hospital, and when certain questions arise in administrative minds as to whether this is truly necessary, there is a direct contact between a medical administrative individual and the physician concerned.

This, we have found, is the most satisfactory method of having those who do not need to be there discharged from the hospital or verifying the validity of their presence there. This is done as contrasted to another procedure of having a committee who go around and make up their minds whether it is over-used or under-used.

THE CHAIRMAN: That is where you have a medical superintendent in the hospital?

DR. MACDONALD: That is correct. In the case of the emergency admission, this has been in the past with us rather a problem because of the broad interpretation that might be put on what is emergent,



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4 and that this might conceivably be considered as a means
5 by which one would not ordinarily get a patient in as a
6 regular admission.

7 Now, in order to control this, there
8 are two elements used. One is that there is, and has
9 been for many years, members of the active staff of the
10 hospital who make up an Emergency Committee and who
11 review or assess these so-called emergent admissions
12 on the basis of their clinical records and in practice
13 it is factual that this assessment only occurs after the
14 patient is within the hospital and the handling of this
15 matter, of course, has to try to educate the man, if he
16 has been broadly interpreting the emergency, that he
17 should not be so broad in his definition and restrain
18 himself to asking for the emergency admission when it is
19 truly so; but, this did not solve the problem.

20 We then have a second situation in
21 which the patient comes to the emergency department,
22 and we have now asked the attendant physician to sign a
23 document in which he certifies that this is truly an
24 emergency as defined in our bylaws, which indicate a
25 condition which, if not immediately attended to, will
26 deteriorate and cause harm to the patient. If he is
27 sincere in his belief that this is an emergent case, he
28 will so sign this thing; and without question, no matter
29 what any administrative individual thinks, that patient
30 is treated as an emergency and a copy of this certifica-
tion is placed in the case record of the patient and is
there available to the examining emergency committee
later on, and there is then a factual evidence that the



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3 man has said it is so, and in fact if it turns out not
4 to be so, one has statistical evidence to present to an
5 individual that his interpretation is not within keeping
6 with what we feel is correct.

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7 We do not actually have to resort to
8 the powers that the senior administrator of the hospital
9 has upon behalf of the Board. We do not have to exercise
10 this to any degree because we feel that the personal
11 contact, the personal education or explanation to the
12 attending staff is the best way to solve it, and when
13 they understand some of the problems of the financing,
14 of the costs involved in the way they are using it, we
15 have found, and I would like to say for the record that
16 the medical staff is most co-operative if they understand
17 why we are trying to do this or to do that. And they
18 have confidence, I feel, that we will not deter them
19 from any serious thing getting attention.

20 This is, in essence, the way we deal
21 with admissions.

22 THE CHAIRMAN: And, Dr. Clare, is that
23 the same at Edmonton General?

24 DR. CLARE: Pretty well, sir, I think,
25 with all the hospitals, more or less. I think they have
26 the most rigid control, and they all have modifications
27 of the same thing.

28 THE CHAIRMAN: And, Dr. Learmonth?

29 DR. LEARMONTH: Sir, we are required
30 to operate a little differently inasmuch as the Royal
Alexandra Hospital is a city-owned hospital.

Basically, we follow this pattern of



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3 admission that Dr. Macdonald has outlined, but because
4 of the fact that we operate as a city hospital, and as
5 a city morgue, we have to accept any people requiring
6 medical treatment that come to our doors, and this puts
7 us in a rather different position, inasmuch as we cannot
8 control our emergency admission to the same extent and
9 this seriously interferes with our use of elective beds.

10 In other words, a high percentage of
11 our bed occupancy is through the emergency holding unit.
12 We use an emergency holding unit. And this, in turn,
13 gives us a high elective waiting list. Otherwise, we
14 function, admission-wise, on the same basic plan that
15 is outlined by Dr. Macdonald and seconded by Dr. Clare,
16 but we do have this added burden by being a city hospital
and city-owned hospital.

17 THE CHAIRMAN: Yes. Thank you very
18 much, Dr. Learmonth.

19 If anyone wishes to add any comments,
20 we will be glad to hear them at this time.

21 DR. CLARE: I have some comments, Mr.
22 Chairman, and they will take five minutes. I would
23 rather not bore you with them now, if ---

24 THE CHAIRMAN: We will assume they are
of consequence.

25 DR. CLARE: Well, they are relating to
26 the statement made by the Minister of Health yesterday,
and I do think they have a bearing.

27 THE CHAIRMAN: Go ahead.

28 DR. CLARE: In commenting on the statis-
29 tics, I feel I would have to differ with the Minister of
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3 Health when he made his reference to quality of hospital
4 care the other day. He made the statement we were in
5 financial difficulties. I am not only referring to our
6 own hospital, but to all six hospitals in Calgary and
7 Edmonton. He referred to a Cadillac service. I do not
8 think for one minute we are giving luxury or superfluous
9 type of service. The reason we are in trouble is because
10 of the volume.

11 THE CHAIRMAN: Financial trouble, you
12 mean?

13 DR. CLARE: Yes.
14 Now, if you will refer to the other
15 day, when the Director of Hospitals was talking about
16 his rated bed-day plan, that there were built-in controls,
17 and he made the reference that he was paying us for our
18 rated beds 365 days a year, but this referred to occupancy
19 of about 80 to 85%, not 100% occupancy. Therefore, it
20 must follow from our statistics, as you see, we are all
21 operating in the neighbourhood of 90 to 96% occupancy,
22 and he is paying us at the rate of 80 to 85%, and we are
23 going to be in financial trouble, and we are. So it
24 should not be surprising, then, that on December 31, 1961,
25 there is an accumulated deficit of \$1,325,000 in the six
26 major hospitals in this province.

27 THE CHAIRMAN: That is, in Edmonton and
28 Calgary?

29 DR. CLARE: In Edmonton and Calgary,
30 yes. This is not to say there will not be an adjustment,
but at the present time we have no idea what that adjustment might be.



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THE CHAIRMAN: How is that being carried out? Is it a bank borrowing, or use of reserve funds?

DR. CLARE: Both, sir.

THE CHAIRMAN: Or unpaid accounts?

DR. CLARE: Well, you cannot go on too far on unpaid accounts and maintain your reputation, but your bank charges are not recognized as part of this. They are in excess of this, any carrying charge. In these six hospitals, as you will appreciate, two are municipal, one is a provincial government hospital, in essence, but Mr. Sherwood says they have their own difficulties in this regard, and the other three are voluntary or Sister hospitals.

I submit, then, that it is unrealistic that the Sisters be forced to meet their deficit from their salaries, whereas these other hospitals have access to municipal or government funds. I do not think this is realistic at all.

Furthermore, I do not really think this is the intention of the Government of Alberta. It does not say so in the Act any place that I know of. As a matter of fact, they said they will be responsible for services rendered.

This leads me to the point of suggesting that since the present scheme is now three-and-a-half years old, and we entered it as a partnership, and it was stressed by the Minister of Health that we were entering as a partnership to serve the people of Edmonton, I feel it is time the partners sat down and reviewed the



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3 situation, find out what the difficulties have been, and
4 see if we cannot rectify them.

5 In suggesting this, I feel it would
6 be necessary to establish a Board or a Commission with
7 representations from, first, the patient or the public,
8 as you may call it, because he is the one receiving it;
9 secondly, the hospitals who are providing the service;
10 thirdly, I think the medical profession, because they
11 are equally as involved; and, finally, the Government.

12 I would further suggest that such a
13 committee should be responsible not to the Department
14 of Health or the Minister, but to the Legislature itself.
15 In this way, we have a particular base committee or
16 commission to which hospital problems could be referred
17 with the reasonable assurance of justice in administration,
18 which I do not feel is now present.

19 Thank you, Mr. Chairman.

20 THE CHAIRMAN: And these are recommenda-
21 tions about how the system could be improved?

22 DR. CLARE: Yes, sir.

23 THE CHAIRMAN: Are there any other
24 comments from anyone else present?

25 We discussed the admission, and there
26 was some reference there by Dr. Macdonald to discharge,
27 but the question of the average length of stay is one
28 that is of some special significance to this Commission
29 because, as you will appreciate, the overall cost of
30 hospitalization under the plan is in the order of about
\$775,000,000 a year. If the average length of stay could
be curtailed by even one day, it is \$75,000,000 to

situation, and cut what the difficulties have been, and
and if we cannot rectify them.

In suggesting this, I feel it would
be necessary to establish a board or a commission with
as you may call it, because he is the one responsible;
namely, the hospital who are providing the service;
that is, I think the medical profession, because they
are equal to be involved; and, finally, the Government,
I would further suggest that such a
committee could be responsible not to the Government
or to the Legislature, but to the legislative body
in this way, to have a particular body committee or
commission on this hospital problem could be related
to the responsible agencies of justice in administrative
with it, so that it is not present.

THE CHAIRMAN: And these are responsible
times and how the system could be improved?

THE CHAIRMAN: And there are other
things from which we are present?
discussed the education, and there
are some proposals made by Dr. Macdonald to discharge,
but the question of the average length of stay is one
that is of some special significance to this Commission
because, as you will appreciate, the overall cost of
hospitalization under the plan is in the order of about
\$5,000 per year, it is \$10,000 per



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\$100,000,000 in a year, and so it is an extremely important topic and, again, we are grateful to you for your figures in Table 4.

Has anyone any suggestions to offer as to how this average length of stay might be shortened, appreciating, of course, the figures you have in Table 1, that if there were a different accommodation you would have the effect of emptying the hospital, but it would still leave the hospital full from your reserve list.

DR. WALLACE: If I may start this, I would point out at the outset that from a business point of view the hospitals - let me say, to start with, that they are all consciously attempting to shorten the stay. From a business point of view under a rated bed-day plan, if hospitals in Alberta were able to lengthen the stay and get more cheap days at the end, we would probably be able to get down into the proper level.

Unfortunately - I should say fortunately, all of the hospitals have decided it is not the approach to the problem and they all have methods of attempting to shorten the length of stay. As the University Hospital in Table 4 appears to be the culprit, 16 days as compared to ---

THE CHAIRMAN: Well, it is not a question of being the culprit; there is an explanation?

DR. SNELL: I imagine you would want an explanation. I would say that the University Hospital has a different type of patient composition from the other hospitals in the city. To begin with there is no D.V.A. Hospital in Edmonton; there is a D.V.A. wing in



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the University Hospital and D.V.A. domiciliary unit in the hospital where they have an average stay of 26.5 days and the domiciliary unit, an average of 79.1 days. Both of these make their effect on the total of 16.1 days.

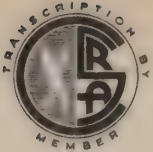
If this were taken out, stay on the civilian average would be 14.25 days.

THE CHAIRMAN: 14.25?

DR. SNELL: Yes. In addition to this the poliomyelitis respiratory centre for the northern half of the province is situated in the University Hospital and the average day stay is 91.7 days. There is also a rehabilitation medicine department with 35 beds with an average stay of 159.7 days. These all have the tendency of keeping the total average high. If the rehabilitation and polio figures were taken out of the picture the average would be 13.3 days.

We still, however, are left with the fact that the University Hospital has within it departments dealing with major and complex conditions; there is a division of cardiovascular service which has an average stay of 21.5 days; there is a division of orthopaedic surgery which serves large numbers of patients with major reconstructive orthopaedic surgery which has an average of 24.7 days. This is the largest orthopaedic section in Canada. These individual departments cause the total picture to be considerably higher than average.

COMMISSIONER VAN WART: Have you an arrangement at University Hospital where patients can be transferred from the other hospitals to your hospital for teaching purposes? For instance, rare disease or



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something of that nature, can they be transferred from one hospital to another?

DR. SNELL: Patients are occasionally transferred but I do not know of any cases where a patient was transferred as an in-patient from any hospital to the University Hospital for teaching purposes. Patients are brought in for teaching purposes.

DR. WALLACE: I believe the Professor of Medicine has information on that.

COMMISSIONER VAN WART: I know one closed teaching hospital the other hospitals in the city supply material to and vice versa; when they are through with the teaching aspect they transfer back to the other hospital and that is at Laval.

DR. WALLACE: Dr. Van Wart, the other three hospitals, affiliated teaching hospitals shown in this list here, undergraduate and graduate teaching is carried on in this hospital and if they have patients of interest they would be presented to our teaching staff by the other hospitals.

THE CHAIRMAN: What we are really concerned about is, is there any possibility of reducing this length of stay? I understand from Dr. Macdonald in his remarks that there was a procedure by which the patient was reviewed in terms of whether he should remain on or be discharged. Have you anything to add to that, any suggestion by which the situation could be improved?

DR. MACDONALD: Well, the obvious answer to us would be as indicated in this survey; if there was another place for certain people, 20%, we



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3 would then be dealing more with the type of case which
4 we, by definition, under Bill 104, are supposed to be
5 dealing with, the acute treatment case.

6 THE CHAIRMAN: We heard about auxiliary
7 hospitals; is that the kind of thing you are talking
8 about?

9 DR. MACDONALD: Yes, they are divided
10 as shown in this table into chronic, convalescent,
11 rehabilitative, domiciliary, home care and all of these
12 facilities, were they available, would help. Now, in the
13 handling of the discharges or the attitude that one
14 takes towards discharges, patients, speaking for myself
15 as a physician and also being involved in the administra-
16 tion side of it, reference has just been made to the
17 fact that if one could stretch it out a little bit
dollar-wise, you could delay ---

18 THE CHAIRMAN: But you appreciate
19 eventually you will pick up your slack and get to a
normal ---

20 DR. MACDONALD: You are torn between
21 the fact of staying out of the red and doing the job
22 for the community, therefore, we have to, as we approach
23 it, we have to try to do a reasonable job in between.

24 THE CHAIRMAN: There is some provision
25 for review in 30 days?

26 DR. MACDONALD: Yes.

27 THE CHAIRMAN: Has it any pronounced
28 effect when this review is supposed to be made?

29 DR. SNELL: I think perhaps one of the
30 problems is when you get to the 30 days review and you



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3 find a patient should have been discharged you find the
4 reason he has not been discharged is that there was nowhere
5 else for him to go. The review merely highlights the
6 difficulty.

7 THE CHAIRMAN: Are there many 28 or 29-
8 day discharges?

9 DR. SNELL: I think the physician
10 would discharge the patient perhaps in 20 days or 28 days
11 but the patient is in the hospital until the 30 days are
12 up because there is no alternative accommodation for him.

13 THE CHAIRMAN: What about home service
14 and referrals and that kind of thing? Could it be
15 expanded?

16 MR. NYE: We are starting now with the
17 V.O.N. to house them directly in the hospital where their
18 nurse can make rounds of the wards, confer with the
19 medical staff and the nursing staff to try to keep a
20 closer touch with the convalescent period of the patient
21 in the absence of a social service department which we
22 cannot provide because of limited funds. We are exploiting
23 the V.O.N. to the extent that they will, in fact, provide
24 a certain type of social service in working with the
25 hospital to remove these patients to their homes on a
26 referral basis with the physician's diagnosis and pres-
27 cription for follow-up care by V.O.N.

28 This is one aspect that we feel will
29 have some positive results. We feel that having explored
30 this and now are ready to implement it that were we in
a financial position to provide social services within
the hospital, that we could utilize many more health:



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3 agencies within the community to expedite the discharge
4 of patients also.

5 This then brings us to a level of
6 operating where I do not feel in any - not contradicting
7 anyone - but I feel we are so under pressure with the
8 emergency situation that we have forgotten temporarily
9 the advantages to the community, to society, in taking
10 care of the so-called elective minor illnesses before
11 they become major illnesses. In this way we would have
12 perhaps more demands but a more rapid turnover of beds
13 and shorter length of stay and we would be looking after
14 the preventive aspects of medicine.

15 I think this would all contribute to
16 the welfare of the community in reducing the active
17 treatment hospital stay.

18 COMMISSIONER BALTZAN: May I ask you
19 to what extent you get the full co-operation of the
20 patient, the patient's family, to achieve this objective
21 or obstructing or objection. Do they feel at times that
22 the administration staff tend to push the public around?

23 DR. NYE: I would have to make an
24 assumption that when any third person steps in to help
25 you plan your private life you rather feel it is an
26 intrusion on your privacy. I feel, with the proper
27 approach, the proper introduction to the family and to
28 the patient, which can be brought about through adequate
29 social services within our hospitals, that we become
30 accustomed to having help in planning in all levels of
our life and I think this is less resented than it would
have been 10 years ago. Have I answered your question?



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COMMISSIONER BALTZAN: Yes, but you still take it into consideration as a factor in considering the whole problem of discharges and even to some extent in the matter of admissions?

MR. NYE: Yes, but then you realize we have no one on our staff that can go in to assist the home situation where there is an invalid or semi-invalid wife where people are living in poor social environmental conditions which will immediately put the patient back in the hospital or where the physical layout of the home, the apartment, the farmstead, whatever it is, is not contributory to the continuing convalescence of this patient.

These are all factors that we have got to give to an adequate social service department within our hospitals to explore before we can cope with the patient and the family. If we can do that and inject a real element of health then the "public" is not going to be shoved around.

COMMISSIONER BALTZAN: So all these things are a factor?

MR. NYE: It remains to a degree, yes.

THE CHAIRMAN: Did you want to say something on this, Dr. Clare?

DR. CLARE: The question of shortening the stay; you may get it down to an ultimate. You take a tonsil case in for 48 hours, the approach to everyone represents a considerable loss. They recover in two days' time, two days of hospitalization, but at the same time you have that patient in the hospital and pay the



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cost of an operating room; it is a gross uneconomical transaction so this way you are trying to shorten the stay to its ultimate, a tonsil case, because of the nature of the scheme.

THE CHAIRMAN: I cannot follow you.

DR. CLARE: For instance, a tonsil case comes into the hospital which requires two days' hospitalization and that would be in the neighbourhood of about \$40. At the outset our costs are \$40. They have to arrange for the case to go to the operating room service which is about \$26 so we have an output of \$26 more. When we put the patient there through our operating room we have an output in the neighbourhood of \$60 to \$65 and we recover \$40.

THE CHAIRMAN: But you keep him another day there.

DR. CLARE: If it depletes your loss.

COMMISSIONER BALTZAN: You are waiting in fear of a haemorrhage.

THE CHAIRMAN: In your newborn average length of stay it is pretty well uniform, 7.3, 7.9. We heard in Newfoundland about the stay as being 3.5. How does this newborn average stay compare with the national average in Canada, can you answer that?

DR. CLARE: I do not have any information.

THE CHAIRMAN: The impression appears to be it is higher than the national average and the only question I have to ask is, why?

MR. NYE: I do not know whether it has



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a direct bearing or not but in our province we have one of the larger of the maternity hospitals under one roof in the province and this brings to this maternity hospital a great many toxemias and prematures which require a longer period of hospitalization than just a straight normal obstetrical case that would be found in this general hospital..

THE CHAIRMAN: It would be easy to accept for the average of four days but they are 7.3, 7.9, 8.3, 8.6.

DR. WALLACE: I was going to say that historically, I at one time was in practice of medicine before I came into the administrative end of it and in Alberta they have a free maternity hospitalization benefit. Having been in rural practice it was the custom there that this was the annual holiday of the farm wife away from the chores and I think this is a traditional length of stay.

THE CHAIRMAN: It would raise the national average yet it is not the farm wife you are giving the holiday to in the City of Edmonton in these four hospitals and you are above the national average; why?

DR. WALLACE: Have we any obstetricians? We have a paediatrician we could ask.



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DR. LEARMONTH: Our obstetrical admissions are 40% now.

THE CHAIRMAN: In Newfoundland they gave us a figure of 3.5. They were almost 100%.

DR. SNELL: I think one of the factors is it is cheaper for the new mother to remain in the hospital for seven days than to come home and get help for the same period of time.

THE CHAIRMAN: That could be. There must be some answer, so that the answer is in the providing of some other service that would relieve the mother and the hospital as well.

MR. NYE: The mother, by the way, is not subject to co-insurance. Maternity is not by co-insurance. The patient is responsible.

THE CHAIRMAN: Do you think that increases the length of stay? Dr. Macdonald?

DR. MACDONALD: I think Mr. Nye and Dr. Snell have answered what was passing through my mind. I would think it does increase the length of stay. It might be relieved by such things as social service-type provision of help at the home.

COMMISSIONER BALTZAN: Which of the two is the best type of medical service rendered, that of the 3.5 days' stay or by the 7.5 days' stay in terms of quality of medical service?

THE CHAIRMAN: I saw some healthy-looking youngsters in Newfoundland. Fifty percent of the population is under 19 years of age. Isn't it nicer to be in the sun than the rain type of thing? Dr. Van Wart?



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COMMISSIONER VAN WART: How did this compare before the plan went into effect?

DR. MACDONALD: Length of stay?

COMMISSIONER VAN WART: Yes, length of stay.

DR. MACDONALD: They are all increasing.

THE CHAIRMAN: Dr. Clare?

DR. CLARE: I would like to refer to a specific area. Our maternity ward; in 1953 we built a new wing. We haven't had any addition to the wing. In 1953 we didn't have the scheme. We didn't have the one dollar.

COMMISSIONER VAN WART: The treatment for maternity has changed. They are now two and three-day. They were then 10 or 11.

DR. CLARE: Our stay at that time was eight days. We handled approximately 1,200 patients in the wing in the one year, 1953. By 1959, when we went into the scheme, we had gone to 1,800 patients and this year we went to 2,300 in the same number of beds.

Our overall stay has not increased in our hospitals.

COMMISSIONER VAN WART: The plan has not increased the overall stay in your hospitals?

DR. CLARE: No.

COMMISSIONER VAN WART: Is it fair to say before the plan you were at capacity and after the plan at capacity?

DR. CLARE: We ran 90 to 94% in the six years.



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THE CHAIRMAN: Thank you very much gentlemen, Mr. Avison and Dr. Wallace, for your attendance here and for your co-operation and willingness to answer the questions and to give us the benefit of your advice and information which has been made available.

DR. WALLACE: On behalf of our two groups, may I thank you for your attention in listening to our problems.

THE CHAIRMAN: We will recess until 2 o'clock.

--- Luncheon adjournment.



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--- On resuming at 2 p.m.
THE CHAIRMAN: The next submission is that of The Canadian Mental Health Association, the Alberta Division; and we shall have a supplemental brief from the southern region.

--- EXHIBIT NO. 123: Submission of The Alberta Division of The Canadian Mental Health Association.

SUBMISSION OF THE ALBERTA DIVISION OF THE
CANADIAN MENTAL HEALTH ASSOCIATION.

Appearances: Mr. B.L. Robinson, President
Mrs. R. Hilland
Dr. James Stewart
Dr. H.E. Smith, Ph.D.
Mr. G.M. Grant Smith, Secretary

THE CHAIRMAN: Mr. Robinson?

MR. ROBINSON: Mr. Chairman and members of the Commission, I take great pleasure in having the opportunity of being here and presenting our brief to you. I would like to introduce my colleagues. Mrs. Ruth Hilland, President of the Calgary Branch of the Canadian Mental Health Association; Dr. James Stewart, the first Vice-President of the southern region of the Alberta Division of the Canadian Mental Health Association; Dr. H.E. Smith, a past president of the Association and a Chairman of our Scientific Planning Committee for Alberta, and Mr. Grant Smith, our Executive Director for Alberta.

Is it your desire, lady and gentlemen, that we read this brief or ---?

THE CHAIRMAN: Well, we will leave it



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4 to your judgment principally. We have been following
5 the procedure of having the summary of conclusions
6 and recommendations read with such amplifications and
7 other statements as you may wish to make and then
8 proceeding to a discussion period, and if we miss out
9 anything you think we should have dealt with, you are
absolutely free at any time to bring that matter up.

10 MR. ROBINSON: Firstly, I would like
11 to say that the Alberta divisional brief deals primarily
12 with the mental health situation in Alberta as a whole,
13 whereas the brief which will be submitted later by Dr.
14 Stewart on behalf of the southern region will deal
15 primarily with the situation in respect to retarded
children.

16 SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

17 1. The Alberta Division of the
18 Canadian Mental Health Association wishes to lay before
19 you a number of points based on Alberta conditions and
experiences.

20 2. We urge that all practices, proce-
21 dures and legislative references, which discriminate or
22 reflect a discriminatory attitude toward mental illness,
23 should be eliminated.

24 3. We urge that in general admission
25 to the mental hospital should be on exactly the same
26 basis as going into any other hospital and that even for
27 those patients for whom some form of legally enforced
28 admission is necessary, the present common practice of
29 apprehension by police and appearance before a police
30 magistrate should be eliminated and made illegal.



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4 In that regard, I would like to say
5 that the situation in Calgary is slightly different to
6 what it is here. They are somewhat further away from
7 the mental hospital which accommodates the people in
8 the southern part of the province, which is in Ponoka,
9 than we are to the one at Oliver, which is close to the
10 city.

11 They have evolved a system where the
12 patients are taken to the hospital and the magistrate
13 will go to the hospital and commit them. We have not
14 been able to bring that into being in the northern part
15 of the province as yet. We are hopeful that we can do
16 that.

17 4. Mental illness should be on the
18 same basis as any other illness in any government hospi-
19 talization plans and legislation and in any medical care
20 pre-payment plans.

21 As you are all possibly aware, there
22 are no medical prepayment plans in existence now which
23 take care of anyone who is unfortunate enough to become
24 mentally ill and in need of treatment.

25 THE CHAIRMAN: And that is excluded
26 even under M.S.I.?

27 MR. ROBINSON: As far as I know it is.

28 THE CHAIRMAN: I thought we heard
29 something to the contrary, but we have not yet heard
30 from M.S.I.

MR. GRANT SMITH: I might say that
M.S.I. allows a certain amount for a person approaching
a private practitioner, but it is not the full amount



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3 of the cost, although some psychiatrists have made provi-
4 sion by which in a group therapy they can accommodate
5 patients, but it does not cover the normal cost of psychia-
6 tric treatment.

7 THE CHAIRMAN: The College of Physicians
8 yesterday told us that this was something they wished to
9 include in the comprehensive coverage.

10 MR. ROBINSON: We would greatly favour
11 that.

12 5. Open hospitals should be the normal
13 condition for all active treatment hospitals.

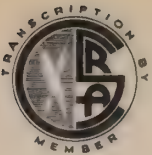
14 In this regard, experience with open
15 hospitals developed in many areas in Great Britain have
16 shown they operate successfully, and a hospital has to
17 do a great deal more work in the community than is
18 possible with the other type of hospital.

19 6. Any federal or provincial legisla-
20 tion designating active treatment mental hospitals as
21 "gaols" should be repealed.

22 7. Persons facing criminal charges
23 should not be remanded to ordinary mental hospitals for
24 mental examination or diagnosis. Psychopathic individuals
25 with criminal or destructive tendencies should have a
26 separate place of detention, probably under federal
27 jurisdiction.

28 8. Regulations in any area discrimina-
29 ting against former mental patients should be eliminated.

30 It is very difficult for a mental
patient coming out of the hospital to obtain employment
now, no matter how well certified to his sanity he may



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be by qualified experts.

THE CHAIRMAN: What do you mean by regulation?

MR. ROBINSON: By regulation, I would take that to mean that most companies have them.

THE CHAIRMAN: You are not suggesting government regulation?

MR. ROBINSON: No, not government regulations. Most companies have clauses -- when you are applying for a job, they ask you, "Have you ever been in a mental hospital?". If you have, that automatically excludes you in many, many cases.

9. Canadian Vocational Training should provide training for a wider range of occupations for former mental patients and an opportunity to catch up on their academic training for young people who have lost their opportunity for ordinary schooling because of illness.

This is particularly discriminatory against a young person who goes to a mental hospital in their early or later school years. They have a very difficult time catching up.

10. The National Employment Service should add to its special placement section in each large community a special officer to find employment for persons with handicaps, including personality handicaps of former mental patients.

11. Sheltered workshops should be established for many who would be otherwise unemployable.

12. Federal and provincial governments



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3 in long term hospital planning should work toward the
4 elimination of the present large and isolated hospitals
5 and encourage the development of local treatment facili-
6 ties in communities, including more psychiatric beds in
7 all active treatment general hospitals.

8 13. Encouragement of the entrance of
9 more individuals into training for psychiatry and ancil-
10 lary professions, clinical psychology, ~~social work~~ and
11 psychiatric nursing, should be given by federal and
12 provincial governments. A school for Social Work should
be established at the University of Alberta.

13 14. Federal and provincial governments
14 should encourage University Departments of Psychiatry
15 to provide continuing seminars and residency training
16 in psychiatry for general practitioners.

17 15. We recommend that the federal
18 government provide generous grants above the normal
19 hospital grant level to encourage the construction of
20 residential treatment centres for emotionally disturbed
children.

21 16. We urge that the expansion of
22 the Alberta Guidance Clinics' services should be continued.

23 17. We urge this Commission to draw
24 to the attention of Departments of Education and local
25 school boards their responsibility for a policy of provi-
26 ding for the detection, treatment and referral of emotio-
nally disturbed children in the school system.

27 18. We ask your Commission to point
28 out to federal and provincial health authorities the
29 problem of the rise in admission of older persons to
30



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3 mental hospitals as an urgent subject for research and
4 study.

5 ~~elimination as one~~ That is our summary and recommendations.

6 ~~referred to as~~ THE CHAIRMAN: Thank you, Mr. Robinson.
7 Do you wish to add anything by way of a running commen-
8 tary in connection with the body of your brief?

9 MR. ROBINSON: Well, we might mention
10 -- on page 5 of our brief, we might add a little to
11 that. That has to do with admissions. That is Section
12 23 on page 5.

13 We have urged in the past that ambu-
14 lances be operated from the hospitals with experienced
15 psychiatrically-trained persons in charge of these ambu-
16 lances. The present practice is to use other types of
17 transportation, and we think that the sooner the mentally
18 ill can have psychiatric help, why, the better their
19 chances of early recovery are.

20 I mention the processes of admission
21 as they differ here from Calgary.

22 Again, on page 4, paragraph 20, we
23 mention there the development of local responsibility
24 for providing mental health services and development,
25 through all these means and others, of a continuity of
26 care for the mental patient. What we have in mind is
27 that local boards might be formed which would have the
28 responsibility for the administration and planning for
29 local-type clinical services for the mentally disturbed
30 person.

31 There is one other factor I would like
32 to stress, and that is the need for research. I just

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Do you wish to add anything by way of a running commen-

tary in connection with the body of your brief?

MR. ROBINSON: Well, we might mention

-- on page 5 of our brief, we might add a little to

that. That has to do with admissions. That is Section

28 on page 5.

It is a very important point, and we think it is

lapses he suffered from the hospitals with experienced

psychiatrically-trained persons in charge of these units

in fact. The present practice is to use other types of

transportation, and we think that the sooner the mentally

ill can have psychiatric help, why, the better their

chances of early recovery are.

I mention the processes of admission

is a very different thing from delivery.

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for providing mental health services and development,

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3 cannot put my hand on it in the brief right now, but our
4 Association believes that the key to the success in the
5 elimination as much as possible of mental illness is
6 research. We believe a great deal of our resources
7 should be directed toward that end, and the search
8 should be continuous and unrelenting because until we
9 get a breakthrough, we are still going to have the
10 mental health problem.

11 I think you know the percentages of
12 people in the hospitals.

13 THE CHAIRMAN: What is your percentage
14 in Alberta? It has been said over Canada, Canada-wide,
15 that it is one out of every two in hospitals in Canada
16 who is in a mental hospital, a mental patient.

17 MR. ROBINSON: I think 35% is what we
18 estimate in Alberta here.

19 THE CHAIRMAN: I see.

20 MR. ROBINSON: I do not think I have
21 anything further to add, unless there are some questions.

22 THE CHAIRMAN: Well, Mr. Robinson,
23 may I put this question to you in a general way? Is
24 your Association satisfied with the present methods of
25 treatment of the mentally ill in Alberta?

26 MR. ROBINSON: As far as they go, they
27 are relatively satisfactory, but we do not think they
28 go far enough as yet.

29 THE CHAIRMAN: You have no specific
30 complaint? For instance, we have heard in some other
provinces -- the description was they were appalling,
and this kind of opinion.

cannot put my hand on it in the brief right now, but our Association believes that the key to the success in the elimination as much as possible of mental illness is research. We believe a great deal of our resources should be directed toward that end, and the search should be continuous and unrelenting because until we get a breakthrough, we are still going to have the mental health problem.

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MR. ROBINSON: There is a definite shortage of proper space for the mentally ill person.

THE CHAIRMAN: By and large, you are satisfied with the progress that has been made to date?

MR. ROBINSON: The treatment methods are improving all the time.

THE CHAIRMAN: You want it accelerated and improved?

MR. ROBINSON: That is right. More facilities and better facilities is what we think is required.

McH7dpw THE CHAIRMAN: Your recommendation number two:

"We urge that all practices, procedures and legislative references, which discriminate or reflect a discriminatory attitude toward mental illness, should be eliminated".

Can you cite by way of example just what you mean there?

MR. ROBINSON: At the present time there are three methods of admission into our hospital.

THE CHAIRMAN: Are you talking about admissions there?

MR. ROBINSON: Partially, yes.

THE CHAIRMAN: What else?

MR. GRANT SMITH: I think the members of the Scientific Planning Committee, who were really responsible for the preparation of this brief, had in mind a number of things which have been mentioned in



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4 detail in some of these other recommendations. The fact
5 that at the present time our mental hospitals are gaols,
6 they feel, is a discriminatory practice that mitigates
7 against the therapeutic program. We know, of course,
8 that in some cases there is no question about the fact
9 that a patient, a mental patient, cannot be a responsible
10 person. However, this can only be determined as a
11 matter of diagnosis.

12 A great many people in mental hospitals
13 there is no need for some of the discrimination, I mean
14 for that class of discrimination.

15 THE CHAIRMAN: What you are talking
16 about is the high-walled institution?

17 MR. GRANT SMITH: Yes, there are some
18 particular practices that might be questioned. There
19 is a good deal of question in the minds of a great many
20 people in psychiatry and I think the Psychiatric Associa-
21 tion in their brief will talk about this; such practices
22 as the fact that a patient in a mental hospital has not
23 the freedom of mail, access to their own mail or to send
24 out mail that any other individual has. That is possibly
25 an illegal restriction.

26 THE CHAIRMAN: What you are concerned
27 with is the adoption of new methods of handling and
28 treatment?

29 MR. GRANT SMITH: On the same basis
30 as any other illness with only a special treatment based
on individual diagnosis, not on a generalized assumption
that a mentally ill person should be so treated.

THE CHAIRMAN: Number 12 on page 3,



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Mr. Robinson, you are advocating the development of local treatment facilities in the communities including more psychiatric beds in all active treatment general hospitals. Do you foresee that as a ward within the hospital or an annex to the hospital administered separately but joined to the hospital for certain purposes?

MR. ROBINSON: Well, we see it as sort of a wing or another ward in the general hospital. I think, as a matter of fact, the Provincial Government is building a hospital in Calgary now where they will have a fairly large number of beds available for psychiatric treatment.

THE CHAIRMAN: Both aspects under the same administration or different administration?

MR. ROBINSON: I will pass that to Dr. Stewart.

DR. STEWART: If I was asked an opinion the opinion would be that they should both be under the same administration because that would be more akin to the recommendation earlier that these people should be treated as other people who are suffering from physical illness are treated. To separate it administratively and by a wing and other ways would seem to be an artifact. It should be one complete unit for the treatment of the people in the community who are ill and have nothing to do with the nature of the illness. My own opinion would be it should be part of the administration of the hospital and not a separate entity.

THE CHAIRMAN: Mr. Robinson, if you are



Mr. Robinson, you are advocating the development of local treatment facilities in the communities including were psychiatric beds in all active treatment general hospitals. Do you foresee that as a ward within the hospital or an annex to the hospital administered separately but joined to the hospital for certain purposes?

Mr. Robinson: Well, we see it as a unit. I think the idea is to have a fairly large number of beds available for psychiatric treatment. I think the idea is to have a fairly large number of beds available for psychiatric treatment. I think the idea is to have a fairly large number of beds available for psychiatric treatment.

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Mr. Chairman: Mr. Robinson, if you are



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3 in a position or any of those associated with you, to
4 answer this question: given a certain amount of money,
5 a certain amount of money being available, just a certain
6 amount of money being available for health services in
7 the Province of Alberta, in what area would you first
8 apply that money? What is the area of greatest need in
9 the matter of health services in the Province of Alberta
10 today?

11 MR. ROBINSON: You mean for mental
12 health?

13 THE CHAIRMAN: I am asking you.

14 MR. ROBINSON: I would think the
15 mental attitude of most of us is probably our most impor-
16 tant human feature and if we are well mentally we are
17 well physically. On that basis I would say if we start
18 to keep our children in a healthy mental condition in
19 later years we would have much less physical disablement
20 and much less mental trouble among our adults.

21 I would say we should start right with
22 our children.

23 THE CHAIRMAN: Number 17 you say:

24 "We urge this Commission to draw to
25 the attention of the Department of
26 Education and local school boards
27 their responsibility for a policy
28 of providing for the detection,
29 treatment and referral of emotionally
30 disturbed children in the school
system".

What is the situation in the elementary

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school system of Alberta with regard to the education of emotionally disturbed children?

DR. STEWART: Sir, in the brief that is to follow we outline the conditions that are ---

THE CHAIRMAN: Would you rather deal with it on that?

DR. STEWART: It would be more logical to deal with it then if you do not mind.

THE CHAIRMAN: Very well, thank you.

COMMISSIONER GIRARD: I would like to ask about the two White Cross centres that you mention on page 6; you say their function is to assist former mental patients to reintegrate into the community; are these in the line of shelter workshops or something like day care or something in between? Could you give us some information on the White Cross centres?

MR. GRANT SMITH: The White Cross centres are not directly therapeutic agencies. Their function is to assist the mental patient to reintegrate into the community, into his family and to resocialize.

Now, possibly we are aware of this, that mental patients usually, if they have been in the hospital for an extended period of time, have been to some extent debilitated and they find it difficult. This is not simply because they have been ill, it is because of the experience in the hospitals as they are at the present time and they lose some ability to live with other people.

This is exaggerated, of course, by their illness and by the fact that possibly, to some



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3 extent, they have felt non-accepted, have not had the
4 affection and understanding of other people. The White
5 Cross centres operate to help overcome that handicap
6 but in doing this we have had to go a little bit further
7 because you cannot just help a man to feel better and
8 let him go out and face a lot of other problems that
9 are going to be too much for him.

10 In both our White Cross centres we have
11 professional workers, they are both psychiatric nurses
12 who have the experience of working with the mentally
13 ill and who know and understand the problems that they
14 face. They help them with counselling and advice and
15 support.

16 In some cases we have, although we
17 are not supposed to be doing this, we have had to help
18 sometimes in things like placement and solution of other
19 domestic problems. We utilize every agency in the
20 community to help us but every once in a while there are
21 problems we have to solve ourselves.

22 COMMISSIONER GIRARD: Would you say
23 these are mostly counselling functions that are rendered
24 in the White Cross centres?

25 MR. GRANT SMITH: Yes, but there are
26 a certain number of employment problems. In another
27 area in the brief we have reference to the Employment
28 Service of Canada and also the Vocational Training Plan
29 and both of these agencies are of help to us. Sometimes
30 we have to go a little beyond them and find friends that
can do a little extra job for the particular person with
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In some cases we have, although we are not supposed to be doing this, we have had to help sometimes in things like placement and solution of other domestic problems. We utilize every agency in the community to help us but every once in a while there are problems we have to solve ourselves.

COMMISSIONER GIBBY: Would you say these are mostly counselling functions that are rendered in the white social centres?

MR. GIBBY: Yes, but there are a certain number of employment problems. In another area in the field we have referred to the Employment Service of Canada and also the Vocational Training Plan and both of these agencies are of help to us. Sometimes we have to go a little beyond them and find friends that can do a little extra job for the particular person with an extra problem.



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DR. SMITH: May I say a word about the organization? The White Cross centre specializes on evening programs. For instance, the one in Edmonton has, about five or six nights of the week, programs of various sorts to which anybody is invited but especially those interested in the program of the evening. This is supplemented by parties and functions of various kinds and displays and shows and facial makeup classes; they have a number of classes which I might mention only the beauticians' class that is put on for anybody interested.

This may operate one or two nights a week.

COMMISSIONER GIRARD: Is this mainly to help the ex-patients socialize, to get them reintegrated into the social life of the community? Would you say that is the main function of the White Cross centres?

DR. SMITH: Yes, it is.

COMMISSIONER GIRARD: You also mention, on page 11, two studies that have been done; one is the treatment facilities for emotionally disturbed children and the second is the schools' provision for emotionally disturbed children. It appears these studies have been beneficial to you; could you make these studies available to the Commission? They might be of help to us and our research division.

DR. SMITH: We would be happy to do that.

COMMISSIONER STRACHAN: Mention is made that a school for social workers should be established at



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3 the University of Alberta. Do you see any possibility
4 of this happening within the next short period?
5 going to look into MR. GRANT SMITH: It is a matter that
6 has been discussed off and on and I do not know how
7 seriously, not being in the inner circles. I would
8 think there is being generated enough pressure in
9 various circles to bring it directly to the attention of
10 the University authorities; every agency in the province
11 as far as I know is short of social workers and are
12 putting on pressure.

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12 COMMISSIONER STRACHAN: Regarding
13 page 3, Number 17:
14 "We urge this Commission to draw to
15 the attention of Departments of
16 Education and local school boards
17 their responsibility for a policy
18 of providing for the detection,
19 treatment and referral of emotionally
20 disturbed children in the school
21 system".

21 MR. GRANT SMITH: This is outlined
22 fairly completely in one of the briefs that we will be
23 making available to you.

24 THE CHAIRMAN: Dr. Stewart said he
25 would deal with it in the next brief. Well, Mr.
26 Robinson and your associates, you probably will be
27 interested to know that this Commission takes a very
28 serious view of this whole question of mental illness
29 and to the extent that it is one of the two areas in
30 which the Commission has set up special studies; one

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Page 6, October 17:

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4 University of British Columbia, who is, in a general way,
5 going to look into the question of morbidity etc., of
6 mental illness and the second study by Dr. McKerricher
7 of the University of Saskatchewan, who will make a study
8 into the changing patterns of treatment of mental illness.

9 These are going to be studies of
10 substantial depth and for that reason perhaps the ques-
11 tioning, the time we may spend with some of these briefs
12 at the public hearings is necessarily less because we
13 have commissioned these special studies.

14 The Commission is going to give very
15 full attention to all aspects of mental health and the
16 treatment of mental disease.

17 Now, the matter of proceeding with the
18 second brief; are you going to do that now?

19 SUBMISSION OF THE ALBERTA DIVISION OF THE
20 CANADIAN MENTAL HEALTH ASSOCIATION.
21 (SOUTHERN DIVISION)

22 Appearances: Mr. B.L. Robinson, President
23 Mrs. R. Hilland
24 Dr. James Stewart
25 Dr. H.E. Smith, Ph.D.
26 Mr. G.M. Grant Smith, Secretary

27 MRS. HILLAND: Mr. Chairman and members
28 of the Royal Commission, representing the Alberta
29 southern region of The Canadian Mental Health Association,
30 I have the privilege of presenting this brief. Our
brief deals with childhood emotional disturbances and
in summary it is in five parts; the first part is, who
will be emotionally disturbed children; second, how

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3 common is the problem; third, why should the problem be
4 of national concern; four, what is now being done for
5 emotionally disturbed children; five, what should be
6 done and recommendations.

7 I would like briefly to give an idea
8 of the incidence of emotionally disturbed children in
9 Alberta.

B/dpw
10 1. Seriously Emotionally Disturbed
11 Children of School Age in Alberta
12 (Needing special psychiatric treatment,
13 hospitalization, special school or
14 home placement) 1,000
15 (Approximately .5% of the school popu-
16 lation).

17 It is noteworthy that in the Brief
18 mentioned earlier, the Scientific Planning Committee of
19 the Alberta Region, Canadian Mental Health Association,
20 argued that there might be a maximum of 200 children in
21 Alberta requiring treatment in residential psychiatric
22 centres. Now, five years later, in a Brief in prepara-
23 tion for this Royal Commission the argument is changed by
24 revising the figure upward. The actual statement now
25 reads, "Our Committee, because of continuing information
26 from local public health authorities in all parts of the
27 province and social agencies and others concerned with
28 the welfare of children, is now convinced that the higher
29 figures than our original estimate are nearer to the true
30 need at the present time".

31 The figure of 1,000 may still be,
32 therefore, too conservative!



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8\6pw

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2. Less Seriously Emotionally Dis-
turbed Children of School Age in
Alberta (Needing clinical referral,
special class placement, and environ-
mental changes) 20,000
(Approximately 8% of the school popu-
lation).

III. WHY SHOULD THE PROBLEM ON THE EMOTIONALLY DISTURBED
CHILD BE OF NATIONAL CONCERN?

Psychiatrists, psychologists, social
welfare officers and juvenile court officials, who deal
with problems of mental disorder, criminality, alcoholism,
and delinquency, are constantly noting that these socially
maladjusted people had childhood patterns characterized
by symptoms of emotional disturbance. There is general
agreement in the professional literature related to the
aforementioned social problems that greater stress on
preventative measures in childhood would have been
advisable.

Thousands of Canadians are leading
unproductive lives at a considerable financial cost to
society. Had the majority of these people been given
early care and treatment, hundreds of thousands of
dollars, if indeed not millions, could have been saved
the taxpayer. Prevention is less expensive than rehabili-
tation; and what is even more significant it is more
defensible in a psychological sense. In brief, prevention
increases the likelihood of a favourable prognosis.

These are, in summary, three major
financial reasons, to say nothing for the social reasons,

2. Less Seriously Emotionally Dis-

turbed Children of School Age in

Alberta (needing clinical referral,

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(Approximately 3% of the school popu-

lation).

III. WHY SHOULD THE PROBLEM ON THE EMOTIONALLY DISTURBED

CHILD BE OF NATIONAL CONCERN?

welfare officers and juvenile court officials, who deal with problems of mental disorder, criminality, alcoholism and delinquency, are constantly noting that these social maladjusted people had childhood patterns characterized by symptoms of emotional disturbance. There is general agreement in the professional literature related to the aforementioned social problems that greater stress on preventative measures in childhood would have less

Thousands of Canadians are leading unproductive lives at a considerable financial cost to society. And the majority of these people have given only one kind of treatment, hundreds of thousands of dollars, to ill and not well persons, could have been saved the taxpayer. Prevention is less expensive than remediation and what is even more significant it is more referable in a psychological sense. In brief, prevention increases the likelihood of a favourable prognosis. These are, in summary, three major

financial reasons, to say nothing for the social reasons,



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3 why this is, therefore, a national problem:

4 1. National productivity is partially
5 imperilled through the loss of thou-
6 sands of potential workers.

7 2. An "army" of employees are required
8 to care for the needs of the emotionally
9 incapacitated adults of society. Many
10 of these workers, too, could be more
11 gainfully employed.

12 3. Costs to the nation in rehabilita-
13 tion of the emotionally incapacitated
14 could be lessened appreciably by posi-
15 tive preventative undertakings.

16 It would seem to be mere common sense
17 to spend thousands today, to decrease the likelihood of
18 spending millions tomorrow. A parallel with business
19 management is obvious. Preventative maintenance is manda-
20 tory in business. Preventative care is mandatory in
21 emotional disturbance!

22 IV. WHAT IS NOW BEING DONE FOR EMOTIONALLY DISTURBED

23 CHILDREN?

24 In Alberta:

25 1. Child Guidance Clinics:

26 There are 3 Full-time Child Guidance
27 Clinics, (Edmonton, Calgary, Lethbridge);
28 3 Part-time Child Guidance Clinics,
29 (Red Deer, Ponoka, Medicine Hat).
30 There are Travelling Clinics from
Edmonton, Calgary and Lethbridge who
visit smaller communities.

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IV. WHAT IS NOW BEING DONE FOR MENTAL DEFECTIVES?

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2.3 There are Residential Psychiatric
in Alberta. In Treatment Centres.

Alberta has in a 12 units for emotionally disturbed
to pre-adolescents exist now: in Edmonton,
over 1000 in an 8-bed diagnostic centre at the
University Hospital; at Red Deer, a
however, there is a 20-bed treatment centre.

There are Special Boarding Schools,
Residential Centres, or Hostels - none
publicly supported.

There are Out-patient Psychiatric
Services of Community Hospitals - 1
Out-patient service at the University
Hospital, Edmonton.

There are In-patient Psychiatric
Services of Community Hospitals - Large
general hospitals in Edmonton and
Calgary have psychiatric wards that
could presumably be used for emotionally
disturbed child cases.

There are Professional Public School
Guidance Services. Edmonton and Calgary
Public Schools employ Directors of
Guidance who each have a team of six
visiting teachers.

There are University Diagnostic and
Research Clinics. An educational
Clinic exists on the Edmonton campus,
and one is proposed for Calgary.

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4 steps in the acceptable direction have been initiated
5 in Alberta. Indeed, there is no reason to suppose that
6 Alberta is in a less favourable position with respect
7 to providing assistance for emotionally disturbed chil-
8 dren than is any other Canadian province. The two
9 crucial questions remaining unasked and unanswered,
however, are:-

10 1. Have the attempts been too feeble?

11 Here and elsewhere in Canada?

12 2. Have the efforts of the diverse
13 groups been co-ordinated?

14 This Brief will return to both these
15 questions in the recommendations.

16 V. WHAT SHOULD BE DONE TO BETTER PROVIDE FOR THE NEEDS
17 OF EMOTIONALLY DISTURBED CHILDREN?

18 Our Recommendations:

19 1. Public Education Needed:

20 The Commission is respectfully requested
21 to devote a considerable section of its findings, which
22 presumably will be given national publicity, to the
23 problems of the emotionally disturbed child. Public
24 awareness of the seriousness of this problem should
25 result in more positive local action. Local support for
26 the employment of school psychologists and other trained
27 personnel in this area should then be greater.

28 2. Subsidization of Training Costs for Professional
29 Personnel:

30 The Commission is asked to give serious
consideration to recommending a system of Federal Govern-
ment bursaries and scholarships, earmarked for graduate

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3 studies in the care and treatment of the emotionally
4 disturbed child. Were one or two Canadian Universities
5 to specialize in this neglected area, and they might be
6 encouraged to do so by special grants, the advantages
7 to the nation would be substantial.

8 3. Extended Child Guidance Services:

9 Expansion of existing Child Guidance
10 Clinics is a pressing need. The Commission is urged to
11 consider the recommendation that minimum numbers of
12 clinics be established on a per capita basis in each
13 province. Furthermore, the Commission is asked to
14 recommend that those provinces which meet these minimums
15 with competent staffs and adequate facilities, be reim-
bursed half the costs by the Federal Treasury.

16 4. Direct Grants to Local School Authorities Who Employ
17 Highly Qualified Personnel in this Area:

18 The Commission is asked to entertain
19 the reasonableness of making direct assistance grants to
20 the Public School authorities in cities similar to Edmon-
21 ton and Calgary who have been farsighted enough to
22 engage the full-time services of school psychologists,
23 and visiting teachers who are charged with responsibilities
in this area.

24 5. Establishment of Child Emotional Disturbance Insti-
25 tutes:

26 There is an obvious need for the
following:

- 27 1. Co-ordination of existing services
28 in this area (Compare the Psychiatric
29 Research Institute in London, Ontario).
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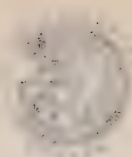
2. A planned approach to long range research projects (Compare the Delinquency Prediction Studies of the New York City Youth Board).

3. A clearing house for recent findings in the field and a source of public information that will be helpful to parents.

4. A distribution body for Federal funds intended to assist approved research projects or any of the other schemes mentioned in earlier recommendations.

It is almost self-evident that one efficient and effective way to cope with the administrative problems envisaged would be establishing a Child Emotional Disturbance Institute with a full-time director. The Institute could be operated by the National Department of Health and Welfare, and be responsible to Dr. Morgan Martin, Chief, Mental Health Division.

Calgary could be considered a possible location for such an Institute. There is a university in the city, and the trend is to establish such Institutes in conjunction with a university. The Calgary Public School Board has shown substantial support and involvement in this vital area and has qualified and interested personnel to assist the Institute. The Canadian Mental Health Association, Calgary Branch, could provide the physical facilities for the Institute in its proposed new building. Certainly, if the Commission were to recommend



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5 make its advantages known. The need for such an Insti-
6 tute, not its location, is however, the major considera-
7 tion in this Brief.

8 THE CHAIRMAN: Thank you, Mrs. Hilland.
9 Have you any questions Dr. Baltzan?

10 COMMISSIONER BALTZAN: Just one, Mr.
11 Chairman. Madam, I am very serious when I say that the
12 figures you present are enough to cause a great deal of
13 emotional disturbance among the adult population. Now,
14 to repeat, you said previously, disturbed, 1,000; half
15 of one-half percent of the total school population and
16 the less seriously disturbed, 20,000 or 8% of the school
17 population.

18 My question is, and perhaps if you
19 can't provide it now, at some later time you could.
20 My question is, how do these figures compare with the
21 indices of national reports?

22 DR. STEWART: May I speak to that?

23 THE CHAIRMAN: Dr. Stewart.

24 DR. STEWART: I have examined the
25 reports for the past ten years in this area in most of
26 our reputable journals. I have studies from England,
27 from Sweden, from France, from the United States and
28 from elsewhere in Canada and I would say that these
29 figures, if anything, are conservative figures.

30 They go as high as 10, 12, 14% of the
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4 this clear by stating that this is a definitive term, it
5 is a matter of degree. What one man may call an emotio-
6 nally disturbed child another practitioner will call an
7 anxious, insecure, nervous child. It is a matter of
8 terminology.

9 When the child is endangering his
10 school career, threatening his social adjustment, and
11 there is a likelihood he is not going to develop into
12 the person he has the potential of being, then we will
13 call him emotionally disturbed.

14 Though these figures initially seem
15 somewhat startling and shocking my considered opinion
16 is, if anything, compared to other studies I have seen,
17 they are conservative.

18 COMMISSIONER BALTZAN: Thank you very
19 much.

20 THE CHAIRMAN: Miss Girard.

21 COMMISSIONER GIRARD: Dr. Stewart, in
22 a former brief, if I can go back to this, one help that was
23 thought of, or one system of early detection of the
24 emotionally disturbed child in the schools, was to have
25 the normal schools put into their curriculum a course
26 that would help them to detect the emotionally disturbed
27 child. Has this been taken up with Board of Education
28 or the Department of Education?

29 DR. STEWART: To answer your question
30 in part, we do, and I am speaking for Alberta, offer a
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COMMISSIONER GIRARD: Dr. Stewart, in a former brief, if I can go back to this, one help that thought of, on one system of early detection of the emotionally disturbed child in the schools, was to have the normal schools put into their curriculum a course that would help them to detect the emotionally disturbed child. Has this been taken up with Board of Education or the Department of Education?

Dr. STEWART: To answer your question in part, we do, and I am speaking for Alberta, offer a course at the University of Alberta at the third year level called Mental Hygiene for the Classroom Teacher,



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4 One area of that course is for symptoms
5 and characteristics and traits of the emotionally dis-
6 turbed child. Of course, we do not anticipate those who
7 take one course will become expert in the capacity of
8 diagnosing in this area. We do think this course we
9 would recommend - it is an elective course and it is at
the third year level.

10 As long as people are not required to
11 take it and as long as only three years of University
12 is required to take a teaching certificate, then there
13 are a great number of qualified teachers in the Province
14 of Alberta who haven't been even exposed to the minimum
requirement of a one-year course.

15 To my knowledge it has not been taken
16 to the Board of Education and asked to be a required
17 course. I think you appreciate the difficulty here.
18 If it is a required course then it would have to be
19 introduced in the first and second year and this would
20 displace something else that is required. It is not a
simple administrative problem.

21 To answer your other question more
22 particularly, I don't know whether this has been suggested
23 as a requirement of teachers. I would certainly think it
24 should be considered as a requirement of teachers to
25 have a minimum of a one-year course in this area.

26 COMMISSIONER GIRARD: Thank you. Have
27 you any idea of what the results have been of the teachers
28 that have taken the course? Did they think it helped
29 them or were they able after that to at least spot some
30 students or schoolchildren with emotional disturbances or



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potential emotional disturbances?

DR. STEWART: This is the critical consideration. When a child's behaviour becomes so obviously disturbed that an inexperienced or inadequately prepared person, in this particular instance, the teacher, can recognize it it is generally by this time the parents will have also recognized it and I suggest it is too late for most of the preventive work we are encouraging.

The subtle characteristics of emotional disturbances such as the ones we hope to see are those that may not generally be detected except by a person who has rather higher skill and training in this area, particularly at the graduate level or the Doctor level preferably and with a considerable degree of practical experience and theoretical preparation.

I feel they detect them too late and by the time they are detecting them a great amount of the preventive work has been lost.

COMMISSIONER GIRARD: This wouldn't be an answer to our question.

DR. STEWART: My experience is that when...

COMMISSIONER GIRARD: It is good, but not good enough.

DR. STEWART: When we expose people to one course they don't usually stop. Many are encouraged to take a second and third and to go to graduate school. That is the type of people we would hope to have ultimately in the system. We would start with one course with the view of getting those to take subsequent courses. I

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3 think this is a positive feature.

4 COMMISSIONER GIRARD: Thank you very
5 much.

6 THE CHAIRMAN: You were going to make
7 reference to Item 17 in the former brief and the matter
8 of drawing to the attention of the Department of Educa-
9 tion etc. Has a submission similar to this been made to
10 the Provincial Government?

11 MR. GRANT SMITH: Only through the
12 Royal Commission, the Cameron Commission on Education
13 which studied the whole field of education. I am afraid
14 our brief got very little reference in the final report
15 of that Commission.

16 THE CHAIRMAN: Is a copy of the brief
17 available and we will have access to it?

18 MR. GRANT SMITH: Yes.

19 THE CHAIRMAN: You would arrange to
20 have it delivered to Mr. Lafrance, I mean sent to Mr.
21 Lafrance?

22 MR. GRANT SMITH: Yes.

23 DR. STEWART: May I draw the Commis-
24 sion's attention to one area of concern here? The
25 recent foundation program for educational support in
26 the Province of Alberta has been criticized for a number
27 of reasons, particularly with respect to this point:
28 those services which are required in the schools such
29 as guidance and counselling services, and those are the
30 ones we are concerned with here, it is the guidance and
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3 the so-called approved cost of a foundation scheme.

4 THE CHAIRMAN: Do we find that in
5 education too, the words "approved cost"?

6 DR. STEWART: In Alberta we do. In
7 local school districts such as Calgary and Edmonton,
8 as were mentioned, in the services obtained, psychologists
9 and visiting teachers, the districts defray the greatest
10 proportion of that cost.

11 A proportion is paid because they are
12 paid as teachers, but not as counsellors or visiting
13 teachers or psychologists. The additional costs have to
be defrayed locally.

14 THE CHAIRMAN: Is this spelled out in
15 the report of the Cameron Commission?

16 DR. STEWART: The foundation program
17 is more recent than the Cameron Commission.

18 THE CHAIRMAN: Where would we find
19 the foundation program?

20 DR. SMITH: The Department of Education.

21 DR. STEWART: The Department of Educa-
22 tion would have it available.

23 THE CHAIRMAN: We will be able to have
24 access to it. Do you want to add anything further, Dr.
Stewart?

25 DR. STEWART: No, I don't think so, sir.

26 THE CHAIRMAN: I am just going to
27 mention again the studies that we have examined in connec-
28 tion with Dr. Richmond's study. He is concerned with the
29 extent of the problem of mental illness; this is so that
30 we will be no longer dealing with the costs or estimates,



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but with the facts as to the extent, to a studied
approach of the subject to be determined. I think we
may give you the assurance that this matter of mental
health is one that is going to receive special considera-
tion by this Commission.

MR. GRANT SMITH: Mr. Chairman, on
behalf of my colleagues and myself I wish to thank you
and your colleagues for the courteous hearing we have
had and we trust your considerations and deliberations
will be very successful.

THE CHAIRMAN: The next submission if
from the Edmonton and District Labour Council.

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4 --- EXHIBIT NO. 124: Submission of the Edmonton and
District Labour Council.

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6 SUBMISSION OF THE EDMONTON AND DISTRICT

7 LABOUR COUNCIL

8 Appearances: Mr. Dave Graham, Executive
Secretary
Mr. Henry Kobe

9 MR. GRAHAM: Mr. Chairman and members
10 of the Commission, my name is Dave Graham. I am the
11 Executive Secretary of the Labour Council, and with me
12 is Mr. Kobe, who is also an executive member of the
13 Labour Council.

14 THE CHAIRMAN: Yes, go ahead, Mr.
15 Graham.

16 MR. GRAHAM: Mr. Chairman and members
of the Commission:

17 This Brief is submitted to you on
18 behalf of the Edmonton and District Labour Council.
19 This Council comprises Trade Unions in the City of Edmon-
20 ton representing over 15,000 members. The Council has
21 consistently taken the position that any matter which
22 might concern its members, whether in terms of their
23 status as Trade Union members or as citizens of this
City, is a matter for its legitimate concern.

24 In submitting this Brief therefore,
25 the Council feels that it is representing a large segment
26 of the public of Edmonton; that its views are not narrowly
27 sectional; that the proposals it has to make here are not
28 made solely on behalf of its members but in the interests
29 of the people of Edmonton and District as a whole.
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4 The Labour movement, of which we are
5 a part, have for a large number of years requested the
6 various levels of Government to introduce a National,
7 Comprehensive Health Insurance plan, which would take
8 care of the Medical and Health problems of the people
9 to the same degree that education, under Government
10 control, takes care of the educational needs of the
11 people.

12 Health Insurance, as we understand
13 and propose to use the term is, we submit, the provision
14 of comprehensive health services to all of the people in
15 the nation through a public scheme. By comprehensive
16 health services we mean complete health care, including
17 preventive and diagnostic as well as curative and rehabi-
18 litative services by physicians, surgeons and other
19 specialists, hospitals and other agencies. In the words
20 of Lord Beveridge:

21 "...a comprehensive national service
22 will insure that for every citizen
23 there is available whatever medical
24 treatment he requires, in whatever form
25 he requires it, domiciliary or institu-
26 tional, general, specialist or consul-
27 tant, and will insure also the provi-
28 sion of dental, ophthalmic and surgical
29 appliances, nursing and midwifery and
30 rehabilitation after accidents".

- (Social Insurance and Allied Services,
1942)

We propose, therefore, for every



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4 citizen all the health care he needs in whatever form
5 he needs it whenever he needs it, without any economic
6 barrier between him and health care. Unless health care
7 is comprehensive, it is bound to be defective in that
8 it will fail in one aspect or another of meeting the
9 needs of the beneficiary. The 'status quo' in medical
10 care results in fragmentation so far as treatment is
11 concerned. A comprehensive program would insure
12 complete treatment through the effective co-ordination
13 of all the resources available to the science of medicine.

14 We believe that the kind of public
15 health insurance program that should commend itself to
16 you and to the Federal Government, should possess the
17 following characteristics:

- 18 (1) It should be universal in
19 coverage.
- 20 (2) It should be comprehensive in
21 scope.
- 22 (3) It should seek to provide medical
23 care of the highest quality.
- 24 (4) It should be free of any co-
25 insurance, deductibles or other finan-
26 cial deterrents against full use.
- 27 (5) It should be financed on a basis
28 which will assure equity in the distri-
29 bution of the burden of cost.
- 30 (6) It should make possible a meaning-
ful relationship between patient and
doctor.
- (7) It should be administered as a



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branch of government with the understanding that all existing and all new health services are to be effectively co-ordinated.

(8) It should have an appeals procedure.

(9) It should provide for an advisory council as part of its administrative structure, such council being representative of the interests of all those who receive the services and those who provide them.

There is no doubt in our minds that some of the other Briefs that you have heard, or will be hearing, will outline to you the large number of gaps that exist in this Province in respect to health care and also we have no doubt that some of the voluntary agencies will be submitting Briefs suggesting to you that a National Health Plan should be left in their hands for administration.

We wish to submit that the private plans are limited almost entirely to diagnostic and curative services. They are limited, generally speaking, to the services of the general practitioner and the specialist. Admittedly these are extremely important; but to these must be added preventive and rehabilitative services, as well as the services which are provided by other than the medical practitioner. Except to a limited extent, preventive measures do not fall within the scope of the private plans and it is difficult for them to accept



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We wish to point out that the private plan
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services of the general practitioner and the specialist.
Admittedly these are extremely important; but so these
must be added, preventive and rehabilitative services, as
well as the services which are provided by other than
the medical practitioners. Except to a limited extent,
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3 this function, partly for reasons of cost, partly that
4 prevention is a heterogeneous field involving many
5 agencies of government and diversified application.
6 Furthermore, there are the services of other professional
7 and quasi-professional workers which are not normally
8 provided. We have in mind nurses, dentists, pharmacists,
9 optometrists, medical and psychiatric social workers,
10 dietitians, practical nurses and others. If comprehen-
11 siveness of services is to be sought, as we urge, the
12 private plans are by their very nature limited and
13 therefore inadequate.

14 The private plans do not make readily
15 available even the kinds of services which are associated
16 in the public mind with them. They abound in exclusions
17 and restrictions. Certain medical or surgical proce-
18 dures may be excluded entirely; others may be available
19 only after a waiting period. There are dollar limita-
20 tions on certain services. In other instances, pre-
21 existing conditions are excluded. An important and
22 obvious exclusion is dental care.

23 The private plans frequently fail to
24 cover the complete cost of the services required. This
25 is especially true of the commercial carriers but it is
26 true also of those that are sponsored by the medical
27 profession. The element of insurance, therefore, is
28 limited and the subscriber is left to carry a portion of
29 the total cost entirely by himself. If he is tempted to
30 avoid this eventuality by dual coverage, he may find
that he is deprived of his membership in one plan or the
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The private plans frequently fail to cover the complete cost of the services required. This is especially true of the commercial carriers but it is true also of those that are sponsored by the national confederation. The element of insurance, therefore, is limited and the subscriber is left to carry a portion of the total cost entirely by himself. If he is tempted to avoid this eventually by dual coverage, he may find that he is deprived of his membership in one plan or the other.



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4 The private plans do not and cannot
5 undertake to guarantee the provision of a service or a
6 facility, nor the proper co-ordination of services.
7 They merely cover a cost or part of it directly or
8 indirectly. To the extent that the community provides
9 hospitals, clinics, laboratories, medical schools and
other facilities, these plans then, enjoy a subsidy.

10 The private plans do not engage in
11 research. It is not in their nature to do so. Here
12 again they benefit by the activities of governments,
universities, foundations and the like.

13 The private plans are not amenable to
14 public scrutiny and control. Admittedly, the medically
15 sponsored plans publish financial statements of their
16 activities but in the final analysis these plans are
17 answerable to organized medicine and not to the consumers
18 on whose behalf they ostensibly exist. So far as the
19 insurance carriers are concerned, these are private
20 corporations pure and simple. They exist to make a
21 profit and quite properly do their best to accomplish
this.

22 What is perhaps the most important
23 objection to the private plans is that they are not
24 concerned with the quality of medical care. They show
25 little or not interest in seeing to it that their subscri-
26 bers obtain treatment at its best. The competence of
27 the practitioner, the availability of facilities, the
28 effective co-ordination of medical personnel and facilities
29 to obtain optimum results, are not inherently their
concern. This is a deficiency of so high an order that

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3 if this were the sole reason for which the private plans
4 were susceptible to criticism it would suffice to carry
5 the day against them.

6 We have not submitted these arguments
7 in an effort to demonstrate that the private plans are
8 of no value. On the contrary, they have served an
9 extremely useful purpose in filling a gap that needed
10 to be filled. Regardless of their weaknesses, they
11 have played an important part in the development of
12 health insurance and have made some degree of medical
13 care accessible to many who could otherwise not have
14 obtained it. But this is simply not good enough at
15 this stage in Canadian history or in the history of the
16 Province of Alberta. It is useless to argue that Canada
17 or Alberta is not ready for health insurance when
18 countries much less blessed with resources have demon-
19 strated beyond any shadow of a doubt that health insurance
20 is practicable.

21 THE CHAIRMAN: Mr. Graham, what do you
22 mean by private plans?

23 MR. GRAHAM: Well, I mean the plans --
24 for example, a number of industries carry plans that are
25 underwritten by insurance companies. The private plans
26 of the M.S.I. -- and, in this province, plans of this
27 nature. That is what we refer to by private plans.

28 THE CHAIRMAN: On page 5, when you
29 say:

30 "What is perhaps the most important
objection to the private plans is
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if this were the sole reason for which the private plans were susceptible to criticism it would suffice to carry the day against them.

We have not submitted these arguments in an effort to demonstrate that the private plans are of no value. On the contrary, they have served an extremely useful purpose in filling a gap that needed to be filled. Regardless of their weaknesses, they have played an important part in the development of health insurance and have made some degree of relief more accessible to many who could otherwise not have obtained it. But this is simply not good enough at this stage in Canadian history or in the history of the Province of Alberta. It is useless to argue that health in Alberta is not really for health first once when account is taken of the fact that resources have been stated beyond the shadow of a doubt that health insurance is practicable.

THE CHAIRMAN: Mr. Graham, what do you mean by private plans?

MR. GRAHAM: Well, I mean the plans -- for example, a number of industrial early plans that are underwritten by insurance companies. The private plans of the M.S.I. -- and, in this province, plans of this nature. That is what we refer to by private plans.

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quality of medical care".

MR. GRAHAM: That is true.

THE CHAIRMAN: You say it is true?

MR. GRAHAM: Yes.

THE CHAIRMAN: All I am asking you is
would you give us some examples of that?

MR. GRAHAM: Well, the private plans
actually are set up to provide a certain service.

THE CHAIRMAN: I mean concrete; some-
thing concrete in Alberta, with M.S.I.

MR. GRAHAM: For example, I am a member
of M.S.I. at the present time.

THE CHAIRMAN: That does not concern
itself with the quality of medical care. That is a
statement there and it must have some evidence to support
it. Well, is there? What is your evidence to support
it?

MR. GRAHAM: I am presently a member
of the M.S.I. in this province, Mr. Chairman, and as far
as M.S.I. is concerned, it does not matter to M.S.I. as
to which doctor I go to -- whether I go to the best
possible doctor in that field or whether I go to the
quack, you might say.

THE CHAIRMAN: Would you want to be
directed -- would you want to have your doctor selected
for you by someone else?

MR. GRAHAM: No, I do not think that
is the point, Mr. Chairman. We are merely pointing out
that in the private plans they are not concerned with
the quality of medical care, in that they are only

quality of medical care".

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3 concerned with paying for the medical care. This is
4 their function. Their function is not to undertake
5 research to provide the highest optimum medical care,
6 but their function is solely to pay under a prepaid
7 plan for medical care, and they are not very much concerned
8 as to the type of medical care that you get. They are
9 only concerned with paying for the medical care.

10 THE CHAIRMAN: Do you take issue with
11 the statement of the Minister of Health, and I am para-
12 phrasing it, that the standard of medical care in Alberta
13 is of a high order?

14 MR. GRAHAM: I would agree with him on
15 that. Yes, I think the standard of medical care in
16 Alberta is of a high order. But I think there are many,
17 many gaps that need to be filled and can only be filled
18 through a comprehensive national health insurance plan.

19 For example, the people -- we represent
20 the people of the lower and moderate income group,
21 salaries. It has been said that a person -- that is,
22 adults with two and three children -- if they are earning
23 less than \$4,000 a year, they are medically indigent.

24 In other words, that while -- if they
25 are up against an illness and not covered by M.S.I.,
26 or by an insurance under the industries they are operating
27 under, that any illness will put them in a position where
28 they cannot pay for the medical care. Many of them, as
29 a result, do not -- simply do not get that medical care.

30 THE CHAIRMAN: Do you know of anyone
who has been without medical care for want of money?

MR. GRAHAM: Yes, I think I can name

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For example, the people -- we represent
the people of the lower and moderate income group,
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adults with two and three children -- if they are earning
less than \$1,000 a year, they are medically indigent.
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or by an insurance under the industries they are operating
under, that any illness will put them in a position where
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4 care at the proper time. They have waited until it was
5 too late, when possibly if we had a health scheme or a
6 national health insurance plan that could have been
7 prevented.

8 THE CHAIRMAN: My question was do you
9 know of anybody who has been without medical services
10 for want of ability to pay?

11 MR. GRAHAM: Oh, yes, very definitely.

12 THE CHAIRMAN: Now, would you care to
13 give us a list in confidence? A list of those names.

14 COMMISSIONER McCUTCHEON: The names
15 of the doctors who refused to give the care, too.

16 MR. GRAHAM: I am not saying anybody
17 who has gone and asked has not received it. I think
18 anyone who will go and ask for medical care will get it.

19 I am saying that due to the absence of
20 money of our people, they are too proud, because they
21 have not got the finances to pay for the medical care,
22 they will put up with the illnesses rather than seek
23 medical advice at the proper time.

24 I am not saying that anyone in this
25 province has been denied medical care who has asked for
26 it.

27 THE CHAIRMAN: Mr. Graham, how many
28 members of the Edmonton and District Labour Council are
29 covered by prepayment plans now?

30 MR. GRAHAM: I would say about 35% of
them.

THE CHAIRMAN: Yes, and that is because

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THE CHAIRMAN: Mr. Graham, how many
members of the Education and District Labour Council are
covered by provident plans now?

MR. GRAHAM: I would say about 350 of
them.

THE CHAIRMAN: Yes, and that is because



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3 they ---

4 MR. GRAHAM: They are either working
5 in industries where they pay as a group, or else they
6 are in an M.S.I. plan. Many times an employer pays 50%
7 of the M.S.I., but we have many, many industries in this
8 area that have no group coverage whatever.

9 THE CHAIRMAN: Now, do I understand
10 you to say that your group -- the Edmonton and District
11 Labour Council -- are interested only in a national plan?

12 MR. GRAHAM: Well, yes, we feel that
13 the national plan is the logical solution.

14 THE CHAIRMAN: What do you mean by a
15 national plan?

16 MR. GRAHAM: Financed by the Federal
17 Government, with preferably the administration left in
18 the hands of the provincial or local authorities, because
19 we feel those are the ones closest to the problem.

20 We feel that the Federal Government
21 should subsidize. We have a hospital plan in the Province
22 of Alberta, but due to the fact that they are curtailed
23 on finances, many of the ---

24 THE CHAIRMAN: Who is curtailed on
25 finances? You made the statement. Now, we are interested.

26 MR. GRAHAM: This is the excuse used,
27 at any rate. The rising cost of hospitals, and due to
28 the approved and unapproved costs at the present moment
29 used in the hospital plan, many of the hospitals are
30 running up deficits that they have got to meet from
other sources, and this is of necessity cutting down the
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4 THE CHAIRMAN: Now, Mr. Graham, you
5 said first financed by Ottawa, and then you used the
6 word "subsidize". Just what did you mean? Did you
7 mean entirely financed by Ottawa -- this national plan?

8 MR. GRAHAM: Well, we are asking --
9 it could be -- the finances could be raised from a form
10 of income tax, but what we want to see is a comprehensive
11 health scheme that is available to anyone regardless of
12 their income; and those with the income.

13 THE CHAIRMAN: And you recognize that
14 is going to cost money?

15 MR. GRAHAM: Well, of course.

16 THE CHAIRMAN: Now, who, in your view,
17 in your submission, should put up the money?

18 MR. GRAHAM: Well, the Federal Govern-
19 ment has access to taxable fields that are outside the
20 jurisdiction of the province, and I feel the Federal
21 Government is the proper body.

22 THE CHAIRMAN: Is that the submission
23 you make?

24 MR. GRAHAM: Yes, that is right.

25 THE CHAIRMAN: And is that your recom-
26 mendation?

27 MR. GRAHAM: Yes.

28 THE CHAIRMAN: Very well. Now, you
29 were saying a moment ago that you found deficiencies in
30 the hospitalization plan due to the shortage of money.

Now, would you care to expand that
further? I take it that statements made like that by
yourself on behalf of a responsible organization are



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further? I take it that statements made like that by

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3 made from some foundation in fact?

4 MR. GRAHAM: Well, I make it not only
5 as a member of the District Labour Council, but I spent
6 two years on the Royal Alexandra Hospital Board, where
7 we were continually running into this problem of approved
8 and unapproved costs, and our city hospital runs up
9 annually a deficit of one-quarter of a million dollars,
10 largely because of the Government's restriction. This
11 is bound to have the effect of curtailment of services
12 that a hospital can give to its patients.

13 THE CHAIRMAN: You were on the Board
14 for two years?

15 MR. GRAHAM: That is right.

16 THE CHAIRMAN: I must say that I think
17 we would be grateful to you for having made your expe-
18 rience available to us. When such a deficit occurred
19 in your time on the Board, where was it made up from?

20 MR. GRAHAM: It was made up by City
21 Council; made up by taxation on the citizens of the City
22 of Edmonton.

23 THE CHAIRMAN: So that the citizens of
24 the City of Edmonton were subsidizing ---?

25 MR. GRAHAM: Subsidizing; reimbursing
26 the city hospital over and above the foundation program
27 of taxation for our hospital purposes.

28 THE CHAIRMAN: Will you tell me -- as
29 you know, the Federal Government under the hospital
30 program contributes roughly 50% of the operating cost of
the hospital. Can you tell me is that deficit taken
into this figure for the division of this 50% division

made from some foundation in fact?

MR. GRAHAM: Well, I make it not only

as a member of the District Board Council, but I spent

two years on the Royal Alexandra Hospital Board, where

we were continually running into this problem of approve

and unapproved costs, and our city hospital runs up

annually a deficit of one-quarter of a million dollars,

largely because of the Government's restriction. This

is bound to have the effect of curtailment of services

that a hospital can give to its patients.

THE CHAIRMAN: You were on the Board

for two years?

MR. GRAHAM: That is right.

THE CHAIRMAN: I must say that I think

it would be grateful to you for having made your expe-

rience available to us. When such a deficit occurred

in your time on the board, where was it made up from?

MR. GRAHAM: It was made up by City

Council, made up by taxation on the citizens of the City

of London.

THE CHAIRMAN: So that the citizens of

the City of London were contributing to it?

the city hospital over and above the foundation program

of taxation for our hospital purposes.

THE CHAIRMAN: Will you tell me -- as

you know, the Federal Government under the hospital

program contributes roughly 50% of the operating cost of

the hospital. Can you tell me is that deficit taken

into this figure for the division of this 50% division



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3 between Ottawa ---

4 MR. GRAHAM: My understanding, Mr.
5 Chairman, is that the administration of the hospitals
6 is solely under the provincial Department of Health,
7 and the grants given by the Federal Government are
8 given to the Provincial Government and the Provincial
9 Government are the ones who lay down what are approved
10 costs, and what are not approved costs.

McH/dpw 11 THE CHAIRMAN: Now, I think we under-
12 stand that but we come now - you say when you were on
13 the Board there was an occasion when there was a deficit
14 of one-quarter of a million dollars in round figures?

15 MR. GRAHAM: Yes.

16 THE CHAIRMAN: Now, just keeping that
17 in mind, that same year the Federal Government was
18 contributing or had agreed to contribute approximately
19 50% of the operating cost of that hospital.

20 MR. GRAHAM: Yes.

21 THE CHAIRMAN: Now, was contribution
22 made on the basis of the operating costs or on the basis
23 of operating costs less the \$250,000 deficit?

24 MR. GRAHAM: I am sorry, I am afraid
25 I cannot answer you because my understanding is this:
26 that the federal grant goes to the provincial Department
27 of Health.

28 THE CHAIRMAN: That is true but it is
29 supposed to be built up by the operating costs of the
30 number of hospitals of the Province of Alberta and the
Royal Alexandra would be one.

MR. GRAHAM: Yes, and the Provincial



MR. GRAHAM: My understanding, Mr.

Chairman, is that the administration of the hospitals is under the Provincial Department of Health, and the grants given by the Federal Government are given to the Provincial Government and the Provincial Government are the ones who lay down what are approved costs, and what are not approved costs.

THE CHAIRMAN: Now, I think we understand that that was the case when you were on the board there was an occasion when there was a deficit of one or two million dollars in round figures?

THE CHAIRMAN: Now, just keeping that in mind, that same year the Federal Government was contributing or had agreed to contribute approximately 80% of the operating cost of that hospital.

THE CHAIRMAN: Now, was contribution made on the basis of the operating costs or on the basis of operating costs less the \$250,000 deficit?

MR. GRAHAM: I am sorry, I am afraid I cannot answer you because my understanding is this: that the federal grant goes to the Provincial Department of Health.

THE CHAIRMAN: That is true but it is supposed to be built up by the operating costs of the number of hospitals of the Province of Alberta and the Royal Alexandra would be one.

MR. GRAHAM: Yes, and the Provincial



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3 Government determines what are the operating costs
4 through their approved and unapproved costs.

5 THE CHAIRMAN: But do you use the
6 word "approved" as synonymous with "operating"?

7 MR. GRAHAM: Yes, I think that is
8 part of the approved cost of the operation of the hospi-
9 tal.

10 THE CHAIRMAN: If you have operating
11 costs that are \$250,000 above the approved cost, the
12 two words cannot be synonymous, can they?

13 MR. GRAHAM: That is true. The
14 approved cost, regardless, it is what the concept of the
15 Provincial Government is as to what should be the actual
operating costs of a hospital.

16 THE CHAIRMAN: Are you able to tell us
17 that, and I am only asking because the information might
18 have come to you as a member of the Board; when the
19 Provincial Government makes up its requisition for 50%
20 from Ottawa are they using the operating figure or the
approved figure?

21 MR. GRAHAM: I am sorry, I am afraid
22 I cannot tell you that.

23 THE CHAIRMAN: With a given amount of
24 money, whatever it may be and only so much money available
25 I mean, if you accept that there is a limit to what a
26 country or province or city might be able to spend on
27 any one budget, have you any views to express on what
is the greatest need in the Province of Alberta today?

28 MR. GRAHAM: I think it is in the
29 preventive field.
30



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through their approval and disapproval costs.

THE CHAIRMAN: And do you use the

word "approved" as synonymous with "operating"?

MR. GRAHAM: Yes, I think that is

part of the approved cost of the operation of the hospital.
Yes.

THE CHAIRMAN: If you have operating

costs that are \$75,000 above the approved cost, the

two words cannot be synonymous, can they?

Approved cost, regardless, it is what the concept of the
financial statement is as to what should be the total
operating costs of a hospital.

THE CHAIRMAN: Are you able to tell us

that, and I am only asking because the information might
have come to you as a member of the board when the

provincial Government makes up its budget for the
year Ottawa are they using the operating figures of the

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THE CHAIRMAN: And not in physicians' services, not merely the providing of physicians' services?

MR. GRAHAM: I think more important is a program of prevention because even in the public welfare field it has been found out that 90% of the welfare cases are welfare cases because of illness, largely because of illness.

THE CHAIRMAN: And the greater dividends would come from spending whatever money is available in that field?

MR. GRAHAM: Yes, within limits because we could not expect to spend all our money just for preventive services although that would cover quite a large aspect of it.

COMMISSIONER BALTZAN: I want to ask a few questions and I want to assure you that this is done entirely on the basis of a searching inquiry and to obtain the local views and regional views in connection with some of these things. You understand your views and the desires of other citizens as well as other segments are equally our concern.

Just one question following the point which was raised by the Chairman a minute ago: your categorical statement regarding the quality of medical care; after you said what you have said would it follow through that the medically indigent receive second or third-rate medical care under the circumstances?

MR. GRAHAM: Well, I think I would be inclined to agree with you that they do.



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COMMISSIONER BALTZAN: I am asking,
I am not telling.

MR. GRAHAM: Yes, I think so.

COMMISSIONER BALTZAN: You go on
record?

MR. GRAHAM: Now, I want to qualify
that.

THE CHAIRMAN: Mr. Kobe is shaking his
head vigorously; is there some agreement?

MR. GRAHAM: I would say a person who
is medically indigent, from the fact he is a medically
indigent person, that he does not seek those services
that he would be getting because he would be allowing
his illness to run to such a degree but not as a result
of lack of medical facilities in this province.

COMMISSIONER BALTZAN: Through his
own negligence?

MR. GRAHAM: Yes, not because of any
lack of medical facilities.

COMMISSIONER BALTZAN: Not because
the quality that is rendered to him is of a second order?

MR. GRAHAM: Yes.

THE CHAIRMAN: You are using the word
"negligence" not in a legal sense, I hope?

COMMISSIONER BALTZAN: I do not know
the legal sense. You say at the bottom of page 4 that
public plans are not amenable to public scrutiny and
control.

MR. GRAHAM: That should be private
plans.



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COMMISSIONER BALTZAN: Public private plans.

MR. GRAHAM: The private plans are not amenable to public scrutiny.

COMMISSIONER BALTZAN: What is the distinction there?

MR. GRAHAM: For instance, the insurance companies who provide a service, the general charge is 15% for administration and their records are not readily available to the public. The M.S.I. do publish a financial statement of their revenue and expenses but other than that you cannot say that they are subject to public scrutiny.

COMMISSIONER BALTZAN: My question then is that M.S.I. and the other bodies operate through private insurance carriers; are there representatives of those who receive the service in the organization, the management of it?

MR. GRAHAM: I think in the M.S.I. in this province there are, yes.

COMMISSIONER BALTZAN: So that is public knowledge?

MR. GRAHAM: The financial statement of M.S.I. is published.

COMMISSIONER BALTZAN: The point is it is not run by any particular segment that there are perhaps just as many representatives of those who give the service and those who receive the service.

MR. GRAHAM: I doubt that. I think M.S.I. and other plans like them are medically-sponsored

Medicaid and other plans like them are medically-sponsored

MR. GRAHAM: I don't think that. I think

the service and those who receive the service.

perhaps just as many representatives of those who give
it is not run by any particular segment that there are

COMMISSIONER BALTZAN: The point is

of Medicaid is published.

MR. GRAHAM: The financial statement

public knowledge?

COMMISSIONER BALTZAN: So that is

in this province there are, yes.

MR. GRAHAM: I think in the Medicaid.

the management of it?

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is that Medicaid and the other bodies operate through

COMMISSIONER BALTZAN: My question the

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cial statement of their revenue and expenses but other

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for administration and their records are not readily

companies who provide a service, the general change is

MR. GRAHAM: For instance, the insurance

COMMISSIONER BALTZAN: What is the

amenable to public scrutiny.

MR. GRAHAM: The private plans are not

plans.



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3 groupings and I think to a large extent are controlled
4 by the medical profession.

5 COMMISSIONER BALTZAN: The medical
6 sponsor is different than managed, are they medically
7 managed only by the medical profession or by those who
8 receive the service, do you know?

9 MR. GRAHAM: Yes, there is some degree
10 of participation by those who receive.

11 COMMISSIONER BALTZAN: Do you know the
12 extent?

13 MR. GRAHAM: No, I do not.

14 COMMISSIONER BALTZAN: Perhaps we will
15 find it out elsewhere. Private plans are limited to
16 almost entirely diagnostic and curative services and I
17 am quoting from page 3. You go on to say that prevention
18 is heterogeneous. I call your attention to and ask you
19 about the contributions and provisions by the Provincial
20 Public Health Department in your province. I call your
21 attention to the Federal Health and Welfare Department's
22 contribution towards prevention for the health of the
23 nation; I call your attention to the National Research
24 Council of medicine for research into medicine; are
25 these contributing greatly, making up the deficiency
26 with the current plans that look after the services,
27 the health services; are these performing their function
28 adequately, in your opinion, these departments of govern-
29 ment?

30 MR. GRAHAM: Oh, I think they are, yes,
but they still have a long way to go, to fill the necessary
gaps that need to be filled.



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COMMISSIONER BALTZAN: I have before me yesterday's publication from Ottawa and it shows defence costs, 27%; finance, 19.2% of the dollar collected; health and welfare, 17.6% compared with ten other things that come around 1% or 2%. In other words, federally speaking, at least, a large portion of the Canadian dollar is spent on health and welfare.

MR. GRAHAM: Yes.

COMMISSIONER BALTZAN: Would you know what the Alberta figure of the collected dollar was?

MR. GRAHAM: I would not know but I am merely making a guess and I would say it would approach that.

COMMISSIONER BALTZAN: So governments are contributing considerably towards the health preventative measures?

MR. GRAHAM: Yes, and I think in our brief we point that out that this form of government spending is actually subsidizing the present private plans.

COMMISSIONER BALTZAN: Are they subsidizing these plans or really paying for preventive measures?

MR. GRAHAM: That the private plans do not provide.

COMMISSIONER BALTZAN: I am not criticizing, I am asking.

MR. GRAHAM: By virtue of the fact the Government are providing this service, if these services were not provided by the Government then the



COMMISSIONER BARTON: I have before

me yesterday's publication from Ottawa and it shows
defence costs, 27% increase, 18.7% of the dollar and
health and welfare, 1.6% compared with ten other things
that come around 17 or 20. In other words, terribly
assembling, at least, a large portion of the Canadian
dollar is spent on health and welfare.

COMMISSIONER BARTON: Would you know

what the Alberta figure of the collected dollar was?
E. GRAHAM: I would not know but I
am merely saying a guess and I would say it would

be something and considerably towards the north of
the dollar.

MR. BARTON: Yes, and I think in our

case we have that our idea of form of government
is being to generally debating the present position
of the

COMMISSIONER BARTON: And then again

that these ideas on really paying for operative
services?

MR. GRAHAM: To the point of and

to not provide.

COMMISSIONER BARTON: I am not certain

about it, I am asking.

MR. GRAHAM: By virtue of the fact

the Government are providing this service, if these
services are not provided by the Government then it's



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3 cost of the private plans would rise accordingly.

4 COMMISSIONER BALTZAN: But are these
5 not actually a function of government?

6 MR. GRAHAM: Yes, we would like to see
7 the Government take over the entire welfare of the
8 people.

9 COMMISSIONER BALTZAN: That is your
10 opinion. Just two things I would like to say on two
11 matters which came to my attention on an investigation
12 of health services in the United States Pacific Coast.
This is what I have been told:

13 "Labour organizations prefer to
14 do business with non-private public
15 prepaid health services in preference
16 to dealing with governments because
17 these organizations are easier to
18 bargain with re costs and easier to
19 come to an agreement with.

20 Do you differ?

21 MR. GRAHAM: Yes, as a matter of fact
22 the policy of the Canadian Labour Congress is for a
national comprehensive health plan by the Government.

23 COMMISSIONER BALTZAN: You do not
24 accept their view?

25 MR. GRAHAM: Well, this is in the
United States and they are different.

26 COMMISSIONER BALTZAN: The next one is
27 not in the form of a question but also complementary
28 to the remark I have just made and it is this:

29 Public private sponsored non-profit
30

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4 prepaid health services, and again,
5 I say what I have heard and what I
6 was told on the coast of the United
7 States of America; these organizations
8 say they prefer labour group member-
9 ships because their members are self-
10 disciplined and they understand better
11 that abuses only tend to increase the
12 cost of service.

13 I think that is quite a compliment and
14 that is the kind of people that should receive favourable
15 consideration. You have heard one set of statements
16 and the other set of statements and I am glad to give you
17 both, whether you agree with them or not.

18 MR. GRAHAM: As far as the organized
19 labour groups covered under the private plans, they are
20 happy with them but we take a much broader view. At
21 the present time we have 13,000 male people unemployed
22 in the City of Edmonton, and, due to the fact they are
23 unemployed and on a very, very low income, these people
24 are deprived of participation in any private groups,
25 they are deprived of even coming under the Public Welfare
26 Act because they are not indigents as such. They may be
27 medical indigents but they are not indigents.

28 Our concern is this group now that
29 cannot pay will not be covered by any private groups.

30 COMMISSIONER BALTZAN: My question is
this: this unemployed group, what is it they need most;
employment?

MR. GRAHAM: That is right, I agree.



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was told on the coast of the United
States of America; these organizations
say they prefer labour group members-
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both, whether you agree with them or not.
MR. GRAHAM: As far as the organized
labour groups covered under the private plans, they are
happy with them but we take a much broader view. At
the present time we have 10,000 white people unemployed
in the City of London, and due to the fact they are
unemployed and on a very, very low income, these people
are deprived of participation in any private groups,
they are deprived of even taking under the Public Welfare
Act because they are not indigents as such. They are not
national indigents but they are not indigents.
The concern is this group now that
unemployment pay will not be covered by any private groups.
COMMISSIONER BARTON: My decision is
this: this unemployed group, what is it they need most;
employment?



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COMMISSIONER BALTZAN: Or health services?

MR. GRAHAM: Well, they do go hand in hand.

COMMISSIONER BALTZAN: If they had employment and ate well and did not worry so much there would be less for the medical men to do.

MR. GRAHAM: That is one way of doing it.

MR. KOBE: Mr. Chairman, there is one more thing I would like to direct to Dr. Baltzan and that is that these plans, such as M.S.I., do have a time limit and in many cases you get struck with a severe illness and 12 or 13 weeks elapse and you are still not ready but your service is cut off and therefore you have to find some other means of getting medical care.

COMMISSIONER BALTZAN: I accept your criticism.

MR. KOBE: It is one part we find quite expensive.

COMMISSIONER VAN WART: I am not quite clear in the Labour submission and turning to page 3 where you say:

"...private plans are limited almost entirely to diagnostic and curative services";

and then you go on to say:

"But to these must be added preventive and rehabilitative services, as well



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as the services which are provided
by other than the medical practitioner".

Now, do you visualize one organization
and one plan taking over the functions of the private
plans, the preventative part and everything under one
big health organization or are you visualizing the
continuation of the Department of Health for preventive
medicine and another group for treatment services and
another group for research or are you visualizing one
great big take-over by the State?

MR. GRAHAM: One administration for
all.

COMMISSIONER VAN WART: For all health
problems of the State?

MR. GRAHAM: Yes.

COMMISSIONER VAN WART: And in the
financing of this does the individual make any contribu-
tion to it outside of his taxes?

MR. GRAHAM: In another part of our
brief we would like to see it done on as equitable a
basis as possible. We know you do not get something
for nothing, everything has to be paid for. We think
the Federal Government could work out a good solution
so the ones who can afford to pay are the ones who will
be paying for these services but everyone should get it
regardless of whether they can or cannot pay for it.

COMMISSIONER VAN WART: By premiums
and so forth from the individual?

MR. GRAHAM: Yes.

COMMISSIONER VAN WART: Under one big



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by other than the medical practitioner

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MR. GRAHAM: One administration for

preventive medicine and another for treatment

medicine of the States.

MR. GRAHAM: Yes.

COMMISSIONER VAN WART: And in the

financing of this does the Federal Government have any control?

From the revenues of the States?

MR. GRAHAM: A portion part of our

total revenue, like to see it as an addition to

what we have now, we know you do not get something

for nothing, everything has to be paid for. We think

the Federal Government could work out a good solution

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huge administrative plan?

MR. GRAHAM: Mind you, under the Federal Minister of Health, but I think it should be administrated provincially and locally. The actual administration of a plan of this nature, I think, would be too unwieldy if it was administered from the one centre with possibly advisory boards representing the public and the various areas being served.

COMMISSIONER VAN WART: Would you visualize a Commission operating the whole thing federally and provincially or leave it in the hands of the Government?

MR. GRAHAM: Well, at least an advisory board to help out the Minister of Health in the administration. I think one thing should be pointed out in a plan of this kind: I do not think it can be brought about all at once, it is something that has to be worked for and brought in a little bit at a time but gradually making for a comprehensive health plan covering all health needs of all the people.

COMMISSIONER VAN WART: Have you any suggestions as to priority? You mention preventative services.

MR. GRAHAM: We are sadly lacking in preventative services at the moment and in all fields of health. I was listening to the brief by the mental health people and I think that is the one feature they have also stressed. I think this possibly might be a field of priority just like fluoridation for the dentists and so on.

have administrative plans?

MR. GRAHAM: Mind you, under the

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health needs of all the people.

COMMISSIONER VAN WART: Have you any

suggestions as to priority? You mention preventative

services.

MR. GRAHAM: We are sadly lacking in

preventative services at the moment and in all fields

of health. I was listening to the brief by the mental

health people and I think that is the one feature they

have also stressed. I think this possibly might be a

field of priority just like fluoridation for the dentists

and so on.



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COMMISSIONER STRACHAN: It is not for the dentists at all, we are working in the public interest.

MR. GRAHAM: That is right, I am sorry.

COMMISSIONER FIRESTONE: Mr. Chairman, I would like to compliment the Edmonton and District Labour Council on its realistic assessment in suggesting a program, a national health program, might perhaps be most realistically developed in stages. You can't do everything overnight.

Canada might have large resources, but not large enough to do everything we want over a short period of time. You are in favour of developing a national health program for Canada, comprehensive in its scope, but developed over a longer period of time as we developed the resources.

MR. GRAHAM: Very much so.

COMMISSIONER FIRESTONE: I think it is a constructive approach. We haven't encountered this approach too often on this point. I welcome your expression of your viewpoint. May I question you on the aspect of such a national health insurance program as you outline at page 2 in your paragraphs 1 to 9.

Your first point, sir, that it should be universal in coverage. Do you have in mind a voluntary or compulsory program?

MR. GRAHAM: I have in mind a program that is available to all the people for all aspects of health needs.

COMMISSIONER FIRESTONE: If people



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4 don't wish to be covered by the program because they
5 want to work out their own arrangements with commercial
6 carriers, do you have in mind under this phrase, it
7 should be universal in coverage, that those who don't
8 wish to be covered should not be covered or should be
covered?

9 MR. GRAHAM: Frankly I don't see how
10 a national health insurance scheme could be successful
11 without covering everyone.

12 COMMISSIONER FIRESTONE: You are envi-
13 saging compulsory coverage?

14 MR. GRAHAM: Compulsory coverage.

15 COMMISSIONER FIRESTONE: Your second
16 point: it should be comprehensive in scope. I think
17 you have been very helpful in your brief in explaining
18 what you mean and therefore there is no need to question
19 you on that, also on the point it should be of the
highest quality.

20 I turn to paragraph 4: it should be
21 free of any co-insurance, deductibles or other financial
22 deterrents against full use. With respect to financial
23 deterrents, the submissions we received from the medical
24 profession of Alberta have also agreed with you, but
25 they expressed the view that there may be some useful
purpose served in including co-insurance. You object to
co-insurance; why?

26 MR. GRAHAM: I object to it on this
27 basis: if the effect of co-insurance is necessary and
28 that a lack of a person coming in on a co-insurance
29 feature may debar him from getting whatever aid - it is
30



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3 in this connection that paragraph 4 turns, dealing with
4 financial return in terms of co-insurance, deductibles
5 or other methods that might prevent a person, who is
6 not a part of this particular scheme, from gaining
7 medical treatment or health care.

8 the physician and COMMISSIONER FIRESTONE: In paragraph 5
9 you speak about financing. You say you would like to
10 see the financing arranged on a basis which will assure
11 equity in the distribution of the burden of cost. Are
12 you referring here to ability to pay?

13 MR. GRAHAM: Ability to pay, yes.

14 fee-for-service. COMMISSIONER FIRESTONE: Thank you.
15 In paragraph 6 you refer to: "...make possible a meaning-
16 ful relationship between patient and doctor". What do
17 you mean by meaningful, sir?

18 MR. GRAHAM: By taking away the
19 financial considerations I think we can actually get a
20 better relationship between the patient and doctor than
21 there is at the present moment. By meaningful relation-
22 ship we also mean that we don't want to take the right
23 of any patient to secure or select their own doctor
24 away, because we feel faith in a person's personal physi-
25 cian is 50% of the cure.

26 COMMISSIONER FIRESTONE: You are in
27 favour of a system of choice?

28 MR. GRAHAM: That is right.

29 COMMISSIONER FIRESTONE: You want to
30 retain the physician-patient relationship that the physi-
cians tell us is so sacred. Thank you.

MR. GRAHAM: Yes.



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THE CHAIRMAN: How would you have the doctor paid?

MR. GRAHAM: We thought possibly of a salary, but not the same salary. We don't agree with the fee-for-service basis. We thought salaries, that the physician should be on salary, but a graded scale such as they use in England where they pay according to the number of patients they serve.

THE CHAIRMAN: Capitation?

MR. GRAHAM: Capitation.

THE CHAIRMAN: You don't support a fee-for-service basis?

MR. GRAHAM: No.

COMMISSIONER McCUTCHEON: What hours would you suggest the doctors work?

MR. GRAHAM: They work 24 now. I would suggest cutting it down to 12.

THE CHAIRMAN: Not a 30-hour week?

COMMISSIONER McCUTCHEON: I don't think you should expect them to work over the weekend.

MR. GRAHAM: No.

COMMISSIONER FIRESTONE: If I may turn to paragraph 7, you say, such a plan should be administered as a branch of government. If the Alberta Government were to select M.S.I. as a designated carrier because they have this experience, because they have the staff, because the medical profession - they have the co-operation of the medical profession; if the Alberta Government were to select M.S.I. as a designated carrier, who would administer such program on behalf of the Alberta



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3 Government, would you be in favour of it?

4 MR. GRAHAM: I don't think we would
5 worry too much about who did the administrating of the
6 scheme so long as it was an all-inclusive, all coverage,
7 scheme.

8 COMMISSIONER FIRESTONE: Therefore
9 you are not firm on the point it must be a branch of
10 the Department of Health; you would want the best agency
11 possible?

12 MR. GRAHAM: We feel the Department
13 of Health of the various levels of government would be
14 the logical persons to do this.

15 COMMISSIONER FIRESTONE: They would.
16 On the other hand if the Alberta Government would
17 consider it better from their point of view to have the
18 scheme administered by such a designated agent on the
19 behalf of the Government of Alberta you would raise no
20 objection?

21 MR. GRAHAM: Providing it was all
22 comprehensive.

23 COMMISSIONER FIRESTONE: Provided the
24 other terms of the plan were in?

25 MR. GRAHAM: Yes.

26 COMMISSIONER FIRESTONE: You state in
27 paragraph 8 there should be an appeals procedure. Do
28 you have anything specific in mind? Are you visualizing,
29 for example, a special appeal tribunal or do you have in
30 mind turning to the courts?

MR. GRAHAM: No, I haven't in mind
appeal to the courts so much as appeal to panels, panel



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appeal to the court to which an appeal to panels, panel



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3 appeals, appeals of this nature.

4 view, you have seen COMMISSIONER FIRESTONE: I think your
5 recommendation 9, for the advisory council, is straight-
6 forward. There is no need to question you on it. I
7 would like, however, to cover three or four aspects
8 not covered in your paragraph 9.

9 visualize the program You have been talking about an all
10 comprehensive health insurance plan. I would like to
11 confine it at the moment to a national medical care
12 plan. Of course, health covers many other facets. We
13 can perhaps concentrate on the limited aspects of a
14 national medical care service plan that meets the nine
15 requirements you have set out.

16 I would like to know if there are some
17 other things you have views on. Did you visualize the
18 Federal Government would make a financial contribution?

19 MR. GRAHAM: Yes.

20 COMMISSIONER FIRESTONE: Would you say
21 this financial contribution could be 50%, 60%; what?

22 THE CHAIRMAN: Mr. Graham suggested
23 the Government paid it all.

24 COMMISSIONER FIRESTONE: I had the
25 impression...

26 MR. GRAHAM: The taxpayers of the
27 country will pay it all under the administration of the
28 Federal Government.

29 THE CHAIRMAN: All the monies channelled
30 through the Federal Government?

MR. GRAHAM: All the monies channelled
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4 COMMISSIONER FIRESTONE: It is your
5 view, you have expressed. I would like to question you,
6 whether you would consider some alternative, whether you
7 feel that the only program that your group would be in
8 favour of would be one where 100¢ out of every dollar
9 would come from the federal treasury or whether you can
10 visualize the program where there would be federal-
11 provincial co-operation in financing the medical care
12 program just as there is a federal-provincial program
13 financing the hospital programs.

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14 MR. GRAHAM: We would have no objection
15 to it. We are not concerned about implementation of the
16 program and the actual administration. How the details
17 are finally worked out isn't of any deep concern as long
18 as we get the program.

19 COMMISSIONER FIRESTONE: You appreciate,
20 sir, we are here to advise the Federal Government. We
21 would like to find out whether you support one type of
22 program or another type of program. I am putting to
23 you the possibility of another type of program that you
24 may not have thought about as yet. I would like your
25 views.

26 You can say you are in favour; you can
27 say you are not in favour; you can say you have no views.
28 My question is, would you visualize, would you support a
29 program whereby the Federal Government would make a
30 financial contribution leaving the operation of the
program and part of its financing to the province?

MR. GRAHAM: As a matter of fact, in
our brief, I think we pointed out we would like to see



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MR. GRAHAM: We would have no objection to it. We are not concerned about implementation of the program and the actual administration. Now the details are finally worked out and out of any basic concerns as far as we got the program.

Now, we are here to advise the Federal Government. We would like to find out whether you support one type of program or another type of program. I am putting to you the possibility of another type of program that you may not have thought about as yet. I would like your views.

You can say you are in favour; you can say you are not in favour; you can say you have no views. The question is, would you visualize, would you support a program whereby the Federal Government would make a financial contribution leaving the operation of the program and part of its financing to the provinces?

MR. GRAHAM: As a matter of fact, in our belief, I think we pointed out we would like to see



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3 the actual operation of the program left with the
4 provinces and localities, and perhaps in this respect,
5 if the provinces and the municipalities provided some
6 of the finances - it is all coming out of one pocket
7 anyway.

8 COMMISSIONER FIRESTONE: We appreciate
9 that. We would like to have your views.

10 Assuming we have a program, administered
11 program, as you have now outlined, would you feel that
12 part of the cost of that program should be financed by
13 the Federal Government, part by the Provincial Government
14 and local authorities, or all 100% covered by the Federal
Government?

15 MR. GRAHAM: I would say all 100% to
16 be covered by the Federal Government.

17 COMMISSIONER FIRESTONE: If the Federal
18 Government came forward with a plan whereby it would only
19 contribute 50%, you wouldn't be in favour of that program?

20 MR. GRAHAM: I wouldn't be opposed to
it as long as we get a health care program.

21 COMMISSIONER FIRESTONE: You wouldn't
22 be opposed to it but you wouldn't especially support it.
23 Let us assume for a moment that your idea of the Federal
24 Government collecting all of the funds required to
25 finance such a program - let us assume that the Federal
26 Government would then have to collect the money in one
form or another to pay for such a program.

27 We have had some figures presented to
28 us in some other provinces on what that might cost.
29 I may say we have had no opportunity as yet to have those
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COMMISSIONER FLETCHER: We appreciate
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MR. FLETCHER: I would say all 100% to
be covered by the Federal Government.

Government came forward with a plan whereby it would only
contribute 75%, you wouldn't be in favour of that program
MR. FLETCHER: I wouldn't be opposed to

it as long as we get a real income program.
COMMISSIONER FLETCHER: You wouldn't

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3 figures checked because they require a good deal of
4 research work. Therefore, I put to you a hypothetical
5 question: on the basis of the approximate figures
6 suggested to us it may involve - if the Federal Government
7 were to cover 100% of the cost of the national medical
8 care plan, that income tax payments by the income tax
9 payers in Canada would have to be raised across the
10 board by 12%.

11 If half of the cost of the program
12 were to come from income tax and if the other half of
13 the cost were to come from corporation tax it would be
14 raising the corporation tax rate by 3% each point, or
15 50 to 53 and from 21 to 24% in cases of corporation
profits thirty-five thousand and less.

16 Would your Council support such a
17 taxation program, income taxes increasing across the
18 board of 12% plus 3% increase in corporation taxes, if
19 these figures turn out to be right? They may be a percent
20 or two less, or higher. We don't know. We have to wait
until our research staff work out the correct figures.

21 If it is something about that, would
22 you go to your membership and say "We are in favour of
23 the program; we can get it if we are willing to pay such
24 taxation rates on top of what we pay now"?

25 MR. GRAHAM: The only thing, I would
26 go to the membership and recommend the program even if
27 it did cost the figures you mentioned, which seem too
high.

28 COMMISSIONER FIRESTONE: It seemed
29 high to us as well. That is why we would like to
30

figures checked because they require a good deal of research work. Therefore, I put to you a hypothetical question: on the basis of the approximate figures suggested to us it may involve - if the Federal Government were to cover 100% of the cost of the national medical care plan, that income tax payments by the income tax payers in Canada would have to be raised across the board by 12%.

If half of the cost of the program were to come from income tax and if the other half of the cost were to come from corporation tax it would be raising the corporation tax rate by 3% each point, or 30 to 60 and from 25 to 45 in cases of corporation profits thirty-five thousand and less.

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3 understand whether you would support such a program.
4 It may turn out the figure will be a lower rate. We
5 don't know. Your answer is you would be willing to go
6 back to the membership and support such an increase in
7 taxes.

8 How about the business corporations,
9 making an increase of 3% in corporation tax rates? The
10 corporations say it would be a disincentive to expansion.
11 It would reduce their ability to save and build up plants.
12 It would raise their costs. It would make them less
13 competitive. They would find it exceedingly difficult
14 to absorb the extra 3% corporation tax.

15 MR. GRAHAM: I am sorry, I have no
16 views on that. I would leave that to the corporations.

17 COMMISSIONER FIRESTONE: Would you
18 still be in favour of such an increase or would you feel
19 everything should be collected through income taxes?

20 MR. GRAHAM: What we are mainly
21 concerned with, and cost is a secondary factor - if it
22 is going to cost an amount as high as you state, then
23 I think we should recognize this thing and accept that
24 fact.

25 COMMISSIONER FIRESTONE: I take it
26 from what you say that you feel it should be paid through
27 taxes and that you would perhaps leave the type of taxa-
28 tion to the authorities that would have to collect the
29 money.

30 MR. GRAHAM: To the politicians who
will have to go and get votes at the next election after
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COMMISSIONER FIRESTONE: To the last point: on page 5, your conclusion. You say it is useless to argue that Canada or Alberta is not ready for health insurance. I take it you refer to a comprehensive health plan such as you have proposed in your submission?

MR. GRAHAM: Yes.

COMMISSIONER FIRESTONE: Could you tell us why, in your opinion, it is useless to argue Canada or Alberta are not ready?

MR. GRAHAM: The only thing we are referring to there is there are countries, countries not nearly as well-developed as Canada, who have comprehensive health insurance schemes.

COMMISSIONER McCUTCHEON: Which countries?

MR. GRAHAM: We have a list. When I say comprehensive health insurance schemes, there are a number of countries that have various. I am sorry, I brought the wrong book.

COMMISSIONER McCUTCHEON: Some are not very comprehensive. You would not trade what you have today for what some of them have?

MR. GRAHAM: That is quite true.

COMMISSIONER McCUTCHEON: They might have a national health insurance scheme in one form or another.

COMMISSIONER FIRESTONE: You are referring to other countries. Let us stick to Alberta and Canada. We don't want to imitate anyone. We want to do it because it is good for us. Why do you feel

COMMISSIONER FIRESTONE: To the last point: on page 5, your conclusion. You say it is useless to argue that Canada or Alberta is not ready for health insurance. I take it you refer to a comprehensive health plan such as you have proposed in your submission?

MR. GRAHAM: Yes.

COMMISSIONER FIRESTONE: Could you tell

us why, in your opinion, it is useless to argue Canada or Alberta are not ready?

MR. GRAHAM: The only thing we are

referring to there is there are countries, countries

not nearly as well-developed as Canada, who have comprehensive health insurance schemes.

COMMISSIONER McCUTCHON: Which

MR. GRAHAM: We have a list. When I

say comprehensive health insurance schemes, there are a

number of countries that have various - I am sorry, I

brought the wrong book.

COMMISSIONER McCUTCHON: Some are not

very comprehensive. You would not trade what you have

today for what some of them have?

MR. GRAHAM: That is quite true.

COMMISSIONER McCUTCHON: They might

have a national health insurance scheme in one form or

referring to other countries. Let us stick to Alberta

and Canada. We don't want to imitate anyone. We want

to do it because it is good for us. Why do you feel



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4 Canada and Alberta are ready for a comprehensive
5 national health insurance plan?

6 MR. GRAHAM: The standard of living
7 is high. The techniques of production are high in
8 Canada, and also at the same time we are a young country
9 just developing. We have the resources to fully substan-
10 tiate a health insurance scheme of this kind. We enjoy
11 a high standard of living. That is the reason we must
12 expect a scheme of this type.

13 COMMISSIONER FIRESTONE: I take it
14 your plan is that our resources are sufficient to develop
15 such a program?

16 MR. GRAHAM: That is right.

17 COMMISSIONER FIRESTONE: If I could
18 come back to what you said earlier, to develop the
19 program of service in line with the resources.

20 MR. GRAHAM: That is right.

21 COMMISSIONER VAN WART: Is your organi-
22 zation willing to contribute through your payroll deduc-
23 tions and premiums, a substantial sum towards the opera-
24 tion of such a scheme as you visualize.

25 MR. GRAHAM: Mr. Chairman, and Dr. Van
26 Wart, I would rather leave this question. The national
27 organization of Canadian Labour and Congress will be
28 submitting a brief to you.

29 COMMISSIONER VAN WART: That is perfectly
30 satisfactory.

MR. GRAHAM: They are more prepared to
go into this than we are here. If it is your wish I
would rather leave it.

Canada and Alberta are ready for a comprehensive

national health insurance plan?

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THE CHAIRMAN: Thank you very much,
Mr. Graham and Mr. Kobe.

MR. GRAHAM: Thank you, Mr. Chairman
and members of the Commission.

THE CHAIRMAN: We will have a short
recess.

--- Short Recess



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THE CHAIRMAN: Thank you very much.

and members of the Commission.

THE CHAIRMAN: We will have a short

--- Short Recess



THE CHAIRMAN: The Alberta Teachers' Association.

--- EXHIBIT NO. 125: Submission of The Alberta Teachers' Association.

SUBMISSION OF THE ALBERTA TEACHERS' ASSOCIATION

Appearances: Mr. M.T. Sillito
Mr. E.J. Ingram

THE CHAIRMAN: Mr. Sillito?

MR. SILLITO: Mr. Chairman and members of the Commission, it is our pleasure to present at this time a brief which embodies the following principles and recommendations.

The following principles are considered basic to an adequate program of school health services:

1. The program must be sufficiently flexible to meet changing circumstances.
2. The program should be planned and administered by adequately trained and experienced personnel.
3. School health services should be well articulated with overall public health services.

The following are recommended:

1. There should exist routine patterns of liaison between public health services to school children and school staffs, psychiatric services, and psychological services.
2. Adequate medical, psychological



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THE CHAIRMAN: The Alberta Teachers'

Association.

--- EXHIBIT NO. 122: Submission of The Alberta Teachers' Association.

SUBMISSION OF THE ALBERTA TEACHERS' ASSOCIATION

Appearances: Mr. M.T. Sillitto
Mr. E.J. Ingram

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2. Adequate medical, psychological



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4 and psychiatric services should be
5 available to all school children.
6 Provision should exist to provide
7 services to children whose parents
8 are unable to do so.

9 The Commission will no doubt notice
10 that these are not directly appointed to the Federal
11 Government or to the Provincial Government or to local
12 health boards. We considered that our purpose in presen-
13 ting this brief was to review the kind of services
14 which it was deemed advantageous and desirable, not to
15 get a little beyond our field into where these services
16 are provided from, who administers them, and who pays
17 for them.

18 SCHOOL HEALTH SERVICES

19 GENERAL

20 Teachers' Concern

21 The teaching profession is interested
22 in the health services provided to school children. By
23 the nature of his profession, a teacher is placed in the
24 position of guardianship over the students in his classes
25 and requires adequate emergency medical service to ensure
26 a proper discharge of this responsibility. The health
27 of students affects their scholastic achievement in many
28 ways. Some of these are obvious. Sensory defects
29 prevent normal perception. Other physical defects may
30 interfere with normal desirable responses to the educa-
tional environment. Emotional disturbances in children
almost always interfere with academic learning. In some
cases a disturbed child may be disruptive of classroom



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tional environment. Emotional disturbances in children
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cases a disturbed child may be disruptive of classroom



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3 procedures thus interfering with the learning of other
4 children. Even when the disturbed child does not
5 disrupt the class, he often does poorly in his own
6 school work. Since the intellectual development of his
7 students is the major professional responsibility of a
8 teacher, he is naturally concerned that the physical
9 and mental health of his students shall be such as to
10 reinforce rather than hinder their intellectual growth.
11 The health of children entering school is a significant
12 factor in the educational process and hence health of
13 pre-school children is also of importance to the teaching
profession.

14 THE CHAIRMAN: Mr. Sillito, do you
15 intend to read the entire brief?

16 MR. SILLITO: Mr. Chairman, no. I
17 had thought that perhaps I would read page 1 and part
18 of page 2 and then highlight some of it.

19 THE CHAIRMAN: Now, you may say, well
20 now, the last delegation read their brief, and it is
21 sort of a little different treatment. You filed yours
22 on time, and we have had an opportunity to read it.
23 The other one only came in at the last minute, and we
hadn't had time to read it.

24 MR. SILLITO: If it is your wish, I
25 think we can proceed on that basis entirely and answer
26 some questions.

27 THE CHAIRMAN: Yes, because you can go
28 on the assumption that the brief has been read.

29 Now, if you want to highlight it and
30 bring out any particular matters to our attention, you



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Now, if you want to highlight it and bring out any particular matters to our attention, you



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4 may.

5 MR. SILLITO: I think, then, that I
6 shall restrict my remarks.

7 Perhaps the point that needs to be
8 made on teachers' responsibility is the partially paren-
9 tal responsibility and the responsibility for the intel-
10 lectual development which may be affected by a student's
11 physical and mental health. On the second page, I think
12 the crux of the matter on liaison is that teachers and
13 the mental health personnel have a common clientele and
14 as such should work as a team.

15 In order to do so, there should be
16 provided routine and adequate means of liaison between
17 the groups.

18 As a remark in the preface to page 3,
19 I would like to observe that in our survey of the prin-
20 cipals throughout the province, we had an adequate res-
21 ponse, so that I think we can safely say that present
22 services are not found seriously inadequate, in general.

23 THE CHAIRMAN: What services?

24 MR. SILLITO: Present public health
25 services provided to schoolchildren by public health
26 units in the province and by the public health boards
27 of the two cities of Edmonton and of Calgary. There is,
28 perhaps, one exception to this, and that will be noted
29 a little later.

30 I would like to say, also, that our
basic principle is that public health personnel should
be given -- should be adequately prepared, experienced,
and given a relatively free hand in designing the service



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Perhaps the point that needs to be made on teachers' responsibility is the partial parental responsibility and the responsibility for the intellectual development which may be affected by a student's physical and mental health. On the second page, I think the crux of the matter on which is that teachers and the mental health personnel have a common clientele and as such should work as a team.

In order to do so, there should be provided routine and adequate means of liaison between the groups.

As a remark in the notes to page 2, I would like to observe that in the survey of the public health personnel the answers we had as adequate responses, so that I think we can safely say that a great number are not sound sections of the state, in general.

Mr. [Name] said that the services provided to a schoolchild by public health units in the province and by the public health units of the two cities of Montreal and of Calgary, there is, perhaps, one exception to this, and that will be noted in the annex.

"What I like to say, also, that can be said is that public health personnel should be given -- should be adequately equipped, experienced, and given a relatively free hand in designing the service



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3 which best fits their districts, and so that the
4 suggested measures, suggested requirements of a program
5 are intended to be neither prescriptive nor all-inclusive.

6 I think, now, I shall go on the earlier
7 assumption made and just highlight the one possible
8 exception where we feel that present services are inade-
9 quate.

10 This is in the area of mental health.
11 We recognize that there are children whose problem is
12 one of mental health, mental disturbance, emotional
13 disturbance, and that there is another group, though
14 not emotionally disturbed, nevertheless, their capacities
15 render them educationally sub-normal. For this group
16 in particular we deem that it is wasteful for these
17 people all to be referred to psychiatric services, and
18 to encumber the provincial health clinics with people
19 whose only difficulty lies in, perhaps, a mental incapa-
20 city to deal adequately with the school situation.

21 So, we have suggested that school
22 services should include adequate psychological assistance,
23 and this, I think, is the one recommendation where we
24 feel our present program is not at the moment reasonably
25 filling the needs of the school health services.

26 I think, Mr. Chairman, that will be
27 the presentation that I would like to make and we would
28 be pleased to attempt to answer such questions as we
29 can.

30 THE CHAIRMAN: Mr. Sillito, we are
indebted to you for the brief and for the clear exposi-
tion of the views that you have put in it.



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4 However, we have some questions that
5 may rise completely outside your brief, because we come
6 to you as the representative of an organization that has
7 very wide coverage throughout the province. I mean, as
8 a Teachers' Association, you are in every hamlet and
9 corner of the province and therefore we are concerned
10 to get, if we can, your views as a consumer group and
11 as a group that is intermittently associated with the
12 consumer groups, the families and so forth, etc., the
13 children through the home and school associations,
14 through all these organizations that are related to the
15 school, to the extent that you may be of some help to
16 us.

17 Has the Alberta Teachers' Association
18 any views to express on the necessity for a comprehensive
19 health program for Canada and Alberta?

20 MR. SILLITO: I think, Mr. Chairman,
21 I would be going beyond a policy area of our group if I
22 made such a statement which is likely to be only a
23 personal opinion. So far as I know, we do not have an
24 established policy in this area as an Association.

25 THE CHAIRMAN: It is not receiving
26 consideration of your Association?

27 MR. SILLITO: That is, I think, fair
28 to say.

29 THE CHAIRMAN: Do you visualize that
30 your Association could be asked to express an opinion on
some of these matters as an Association?

MR. SILLITO: Yes. I think, Mr.
Chairman, a request to express an opinion might



however, we have some questions that may rise completely outside your brief, because we come to you as the representative of an organization that has very wide coverage throughout the province. I mean, as a Teachers' Association, you are in every hamlet and corner of the province and therefore we are concerned to get, if we can, your views as a consumer group and as a group that is intermittently associated with the consumer groups, the families and so forth, etc., the children through the home and school associations, through all these organizations that are related to the school, to the extent that you may be of some help to us.

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MR. BILLITO: Yes. I think, Mr. Chairman, a request to express an opinion might



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necessarily take some time. It could be forthcoming.

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THE CHAIRMAN: How much time? I suppose you have a meeting around Easter-time? Do you follow the same practice to have your executive meet at Easter-time, as in Saskatchewan?

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MR. SILLITO: There is a meeting of the Parliament of the Alberta Teachers' Association called the Annual General Meeting at Easter-time.

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THE CHAIRMAN: Yes.

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MR. SILLITO: Would it be your wish, Mr. Chairman, that ---

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THE CHAIRMAN: Well, now, would this be a procedure that might be acceptable -- that if our research department would communicate with your Association reasonably soon -- that is, quite soon -- with certain specific requests so that you might have them considered at your Easter Parliament?

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MR. SILLITO: I think that the Association would be quite willing to undertake to do what it could in the area of its responsibility.

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My suggestion, as a representative of the Association, is that there are two things we could not be expected to do: go very far afield of our area of responsibility for education and its related concerns; and, secondly, some requests might, by the very nature of them, require more time than would be available.

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I am not suggesting that we are not willing to use our professional organization.

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THE CHAIRMAN: Do you accept the validity of the suggestion that I have made to you that you



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be a procedure that you would accept? -- that is, our

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MR. MILLER: I think that the Associa-

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the Association, is that there are two things we could

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of them, require more time than would be available.

I am not suggesting that we are not

willing to use our professional organization.

THE CHAIRMAN: Do you accept the vali-

dity of the suggestion that I have made to you that you



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3 are a representative consumer group?

4 MR. SILLITO: Yes, I do, sir.

5 THE CHAIRMAN: And one that has a
6 very fine opportunity of being well-informed?

7 MR. SILLITO: Yes, sir.

8 THE CHAIRMAN: And it is for that
9 reason that we would like to be able to come to you --
10 not necessarily today, and I appreciate your position --
11 for some views, and if you are agreeable we will have
12 the request made to you in writing and quickly.

13 MR. SILLITO: I think this would be
14 acceptable to our executive.

15 THE CHAIRMAN: In that context, I
16 think we can only just ask you to leave it at that and
17 then you will hear from us quite soon and we would be
18 very grateful for the consideration that we know the
19 Teachers' Association is capable of giving and for any
20 leadership that you may care to show in the discussion
21 of this very important public question of a comprehensive
22 health service program.

23 MR. SILLITO: Thank you.
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executive, association is capable of giving and for any

indication that you may care to show in the discussion

of this very important public question of a comprehensive

health service program.



THE CHAIRMAN: Now, we will hear from
the Medical Services (Alberta) Incorporated.

--- EXHIBIT NO. 126: Submission of The Medical Services
(Alberta) Incorporated.

SUBMISSION OF THE MEDICAL SERVICES
(ALBERTA) INCORPORATED

Appearances: Mr. F.T. Jenner
Dr. S.M. Schmaltz
Mr. L.W. White

THE CHAIRMAN: Mr. Jenner?

MR. JENNER: Yes, sir. Mr. Chief
Justice Hall, and gentlemen of the Commission, first of
all, with your permission, I would like to introduce my
colleagues, Dr. Schmaltz on my left, General Manager of
M.S.I. and Mr. White, board member.

It is our intention, if it is agreeable
to you, to read the first page of our brief, which is
our summary and recommendations, and then we would be
available for whatever use you would like to make of us.

THE CHAIRMAN: Yes, there are some
areas in which we would like to get a little more informa-
tion from you.

MR. JENNER: Thank you, sir.

SUMMARY

1. This brief is presented on behalf
of the members of Medical Services (Alberta) Incorporated.

2. It confines itself to costs of the
provision of medical services as related to paragraphs
(g), (h) and (i) of the Order in Council.



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THE CHAIRMAN: Now, we will hear from

the Medical Services (Alberta) Incorporated.

(Alberta) Incorporated.

MEMORANDUM OF THE

(ALBERTA) INCORPORATED

Presented by: Mr. T.T. Jenner
Mr. G.M. Schmitt
Mr. L.A. White

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3. It excludes costs of physicians' services traditionally assumed by governments, the Workmen's Compensation Board, Cancer Clinic, etc.

4. The practicality and feasibility of making available on a voluntary prepayment basis, physicians' services to the majority of the citizens who desire it, irrespective of age, pre-existing conditions, or eligibility for group enrolment, is demonstrated.

5. It shows that physicians' services on a voluntary pre-paid basis are available to all citizens -- albeit some citizens require assistance, in whole or in part, to finance the costs.

6. A plea is made for the preservation and strengthening of the free enterprise system in the provision of medical care by having the individual retain and exercise his liberty and responsibility.

RECOMMENDATIONS

1. That in the provision of physicians' services, the free enterprise system be maintained.

2. That assistance be given those individuals who require it to pay or prepay the cost of their medical care.

3. That further studies be made of the needs for assistance in the payment or prepayment for their medical care of those segments of society whose needs are not known, for example, the over 65 age group without coverage.

4. That the voluntary prepayment plans be allowed to further develop and expand their



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6 One other point, in view of the fact
7 it was raised in the previous submission, the members
8 of the Board are seven; four laymen and three doctors.
9 The four laymen come from different walks of life and
10 excluding the two of us here, we feel they are reasonably
11 capable.

12 THE CHAIRMAN: By what process is the
13 Board constituted at seven? How are they chosen?

14 MR. JENNER: They are elected at the
15 annual meeting for terms of two years and certain ones
16 each year ---

17 THE CHAIRMAN: Staggered retirement?

18 MR. JENNER: Yes. They are from three
19 groups, administrative groups, the member group and one
20 from the medical profession and one is elected by the
21 other six at an open meeting.

22 COMMISSIONER FIRESTONE: Mr. Jenner,
23 do the M.S.I. contracts include a right to cancel the
24 policy?

25 MR. JENNER: Yes, sir.

26 COMMISSIONER FIRESTONE: Is this right
27 exercised frequently?

28 MR. JENNER: No sir, the only time we
29 have exercised it, I have no evidence of it ever being
30 exercised for over-utilization but it has been exercised
in the early days of our operation because we had certain
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contract.

We have to do this, it is a legal requirement.

COMMISSIONER FIRESTONE: Could you elaborate the last point?

MR. JENNER: Well, the legal counsel tells us if we have a contract in effect and wish to change the benefits on it we have to amend it or cancel it. I think over the years, the General Manager can confirm this, there has been a system of ---

THE CHAIRMAN: Even if you are extending the benefits without additional cost?

DR. SCHMALTZ: What has happened, in effect, we notify our groups that certain benefits are being incorporated and because we do not want a multiplicity of contracts in effect we ask them for an acceptance of the new contract.

If this acceptance is not forthcoming then by our anniversary date we notify them of cancellation. In most cases it has not been forthcoming because someone put it in the lower right hand drawer and forgot to send it in.

COMMISSIONER FIRESTONE: If I understand you correctly you do not use this cancellation right because somebody has more than exhausted the rights that he has under the plan? You only exercise this in very special circumstances. I presume you can exercise it in the case of misrepresentation or what have you but as a rule you have not exercised this right except for legal reasons frequently.



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DR. SCHMALTZ: That is right.

COMMISSIONER FIRESTONE: Are you familiar with the cancellation rights, the cancellation clauses in commercial contracts? Are they somewhat similar to yours? By "commercial contracts" I refer to those of insurance companies, casualty companies.

DR. SCHMALTZ: I am not too familiar with them. Our cancellation clause is a 30-days prior notice prior to the anniversary date of the contract.

THE CHAIRMAN: Prior to the anniversary date, not just any 30 days?

DR. SCHMALTZ: Anniversary of the contract.

COMMISSIONER FIRESTONE: Are you familiar as to whether these cancellation rights are used more frequently by commercial carriers than by M.S.I.?

DR. SCHMALTZ: To answer that question I would have to go back to my days as a medical practitioner before I became an administrator.

In those days my personal experience with commercial companies was, yes, that they were applied.

COMMISSIONER FIRESTONE: And they were applied under what circumstances, based on your experience of patients you may have had?

DR. SCHMALTZ: Generally speaking, when a patient developed an illness which would tend to recurrences, complications. For instance, one of the prime examples I remember is a lady who had coverage with one particular carrier and she had benefits for the



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first episode which happened to be a mild stroke and her contract was cancelled for any cardiovascular condition that might result in the future.

COMMISSIONER FIRESTONE: In other words, a person that goes ahead and obtains a contract to protect himself or herself against contingencies and when those contingencies of ill health occur and they are of a continuing nature, in other words, in the situation where a patient needs protection most, these cancellations are applied according to the example which you have given?

DR. SCHMALTZ: According to that example, yes.

COMMISSIONER FIRESTONE: Were there other examples or was that just an isolated case?

DR. SCHMALTZ: I can remember one other example where there was no cancellation but there was a rider after an appendectomy that they would not accept responsibility for almost anything that could happen within the abdominal cavity, peritonitis, haemorrhage of the bowel or anything else.

COMMISSIONER FIRESTONE: It is not the patient's fault but he would not have the protection after he had the appendicitis. Do I understand the patient has this type of coverage, if they shift it over to M.S.I. coverage they would be covered?

DR. SCHMALTZ: Yes, sir.

COMMISSIONER FIRESTONE: So they would be better off in your type of coverage than the commercial coverage?



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DR. SCHMALTZ: That is our opinion.

COMMISSIONER FIRESTONE: How about the comparability of premiums that are being paid, comparable premiums that the people pay for an M.S.I. policy and for a commercial policy of the same type of coverage?

DR. SCHMALTZ: I am not too familiar with that. I cannot give any definite figures for the same range of benefits that we have. I do not know of any commercial contract that can match this particular premium.

COMMISSIONER FIRESTONE: In other words, what you are saying, if I understand you correctly, is that the public of Alberta get the widest coverage for what they pay in terms of premium and there is no commercial carrier that matches this in relation to premium payments, to the service provided? Am I correct in that understanding?

MR. JENNER: Well, I do not know whether Dr. Schmaltz can answer this but certainly I cannot. We have not gone at things in this way. We have never developed any figures and perhaps we are wrong. Perhaps we should feel we are in serious competition with some people but we have not felt that way nor have we moved that way.

I just could not tell you whether this corporation could beat London Life or not. We have no figures available on that.

COMMISSIONER FIRESTONE: All you have to say is this information is not available. What we



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5 and how it compares with other types. As I understand
6 from the discussion we have had on cancellation arrange-
7 ments, the answer was that they get a much broader
8 coverage and less cancellations than they would get from
9 a number of commercial carriers. Now, if we are trying
10 to establish whether this is also true in terms of
11 dollars and cents they pay, if the information is not
12 available then it is not available and we can take it
there is no comparable information available.

13 MR. JENNER: I have not got it.

14 DR. SCHMALTZ: No, nor I.

15 COMMISSIONER FIRESTONE: What happens
16 if somebody has an M.S.I. contract and takes sick on a
17 protracted basis and cannot pay the premium?

18 MR. JENNER: He is covered for six
19 months regardless on individual contracts.

20 COMMISSIONER FIRESTONE: Now, if some-
21 body becomes unemployed and cannot pay the premium?

22 THE CHAIRMAN: Excuse me, you say he
is covered for six months?

23 MR. JENNER: Yes.

24 THE CHAIRMAN: If he is continuously
25 ill and at the end of that time he is still ill from the
26 sickness he had when the contract was in force, what
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27 DR. SCHMALTZ: Just to clarify this;
28 he is continuously covered for six months, we waive the
29 premium for six months. Now, if he can pay his premium
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5 six months. For the insured, that is the head of the
6 household, and for his dependents; three months.

7 THE CHAIRMAN: Even if the illness,
8 his precipitating cause arose during the period when
9 it was in force?

10 DR. SCHMALTZ: He has a waiver of
11 premium for six months.

12 COMMISSIONER FIRESTONE: Now, if the
13 same person, if a person becomes unemployed and he
14 cannot pay the premium, what happens then?

15 DR. SCHMALTZ: He has no coverage.

16 COMMISSIONER FIRESTONE: He would then
17 become what has been described to us as a medically
18 indigent person?

19 MR. JENNER: Yes, I suppose you could
20 apply that term to it, yes.

21 COMMISSIONER FIRESTONE: I understand
22 that your plan publishes an annual report and statement?

23 MR. JENNER: Yes, sir.

24 COMMISSIONER FIRESTONE: Is there any
25 other public scrutiny or control besides publication of
26 this report?

27 MR. JENNER: Only from the point of
28 view of the auditing firm, the national firm with a
29 reputation to maintain.

30 COMMISSIONER FIRESTONE: Would you
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6 organization by the provincial superintendent of
7 insurance or under the federal organization under the
8 federal department of insurance? Would you consider
9 this reasonable in the interest of protecting the public?

10 MR. JENNER: I would certainly have no
11 objection but I could not see the reason why they would
12 want to when there is a public statement published.

13 COMMISSIONER FIRESTONE: Of course,
14 you are perhaps in a somewhat better position than
15 other plans because you do publish the statement and
16 give the public an opportunity to scrutinize and you
17 realize many other plans do not. Furthermore, you
18 realize many of the plans, many of the policies have a
19 number of conditions and terms attached which are
20 printed in very fine print.

21 The question always arises, of course,
22 whether, if we had a system of public control, we might
23 not develop a minimum standard of coverage so that some
24 of the companies that have rather burdensome terms in
25 the small print, which the average person does not read,
26 would maybe have to follow a desirable minimum standard
27 of terms and conditions.

28 Would you, in the interest of having
29 an efficient and reasonable service industry in your
30 own field develop, would you be in favour of such a
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4 statement without some consideration by my colleagues.

5 DR. SCHMALTZ: It is my understanding
6 that all insurance carriers in this province that are
7 listed as insurance carriers, which we are not, if you
8 have referred to the exhibit, do come under the superin-
9 tendent of insurance.

10 COMMISSIONER FIRESTONE: Yes, to report;
11 but the superintendent of insurance is not called upon,
12 if you examine both the statute and the practice, to
13 examine the terms and to assure minimum standards of
14 performance or to check the fine print as far as the
15 terms applicable to the purchasers are concerned.

16 They are, of course, bound by certain
17 overall regulations and presumably the superintendent
18 of insurance will make sure the law as it stands is
19 properly administered. However, I am referring to the
20 particular aspect that concerns the developing of minimum
21 standards by carriers of health insurance and the fact
22 that if such standards are developed somebody has to
23 make sure that they are followed.

24 Now, it may be achieved through self-
25 discipline among the industry or achieved through a
26 control system. Have you any thoughts on the subject?

27 MR. JENNER: I think we can only say
28 we have not any objection unless it costs us money to
29 raise our rates. This is always one of the dangers of
30 controls because somebody comes along and says "Why
haven't you got this?" and if you add that they do not
realize it will cost this many more cents. We have not



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DR. LCHAMATZ: It is my understanding

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4 any objection to the superintendent of insurance or
5 some other body in the Government coming to us and
6 examining our statement but we have a right and proper
7 objection to them saying we have to do this and that.

8 Can we do it with our costs?

9 DR. SCHMALTZ: May I make a comment
10 to clarify what has been asked? In 1954 we were
11 approached by the Provincial Government and negotiations
12 went on under an act which was mentioned yesterday, I
13 think, or the day before, where the Government was
14 considering subsidizing the premium by a certain percen-
15 tage, roughly one-third for all those people who had
16 coverage.

17 The Government asked the Board at that
18 time whether its books would be open and the Board agreed
19 they would be open to the Government at any time.

20 COMMISSIONER FIRESTONE: That is a very
21 helpful answer. May I turn now to another question?
22 Could you tell us what proportion of your revenues from
23 premium income in 1960 or 1961, whatever the latest
24 figures are available, how much went into administration
25 costs?

26 DR. SCHMALTZ: 8.3% of revenue in
27 1960 and I think it was 8.3% the previous year as well.

28 MR. JENNER: We have it on cents per
29 thousand.

30 COMMISSIONER FIRESTONE: The figure
you gave is quite adequate. This is just for the purpose
of illustration and it was 8.3% in 1960?

MR. JENNER: Yes.



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COMMISSIONER FIRESTONE: Did you also put any funds aside for reserves in that year?

MR. JENNER: Oh, yes.

COMMISSIONER FIRESTONE: What proportion would you say did that involve?

DR. SCHMALTZ: 1960, if I read correctly, was 7%.

COMMISSIONER FIRESTONE: In other words, if your administrative costs were a little over 8% and your reserves absorbed 7% you have, in effect, paid 85% out of every dollar received to the physicians, is that correct?

DR. SCHMALTZ: 86.2 in 1960.

COMMISSIONER FIRESTONE: 86.2 in 1960?

DR. SCHMALTZ: Yes.

COMMISSIONER FIRESTONE: In other words, you paid roughly 86 cents out of the dollar back in terms of medical care services which have been received by the subscribers under your plan?

DR. SCHMALTZ: The estimated unrepresented claims for the services for that year are not included.

COMMISSIONER FIRESTONE: If we use your first figure it would work out to between 85 and 86 cents on the dollar has been paid out in terms of the services which your subscribers have received from physicians?

DR. SCHMALTZ: Correct.

COMMISSIONER FIRESTONE: Are you familiar with the fact that some of the commercial carriers pay only 40 or 50 cents out of the dollar?

DR. SCHMALTZ: I have been so informed sir.



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COMMISSIONER FIRESTONE: Therefore, any-
one acquiring a policy from your association gets a
much better deal than from those carriers that only pay
out 40 or 50 cents?

DR. SCHMALTZ: That is previously
stated.

THE CHAIRMAN: The doctors may get a
better deal.

COMMISSIONER FIRESTONE: If an
insurance company pays out 40 or 50 cents out of a dollar
received the doctors will be receiving less out of the
dollar than if they get 85%. Are they getting 85% from
you?

DR. SCHMALTZ: 86%.

MR. JENNER: The difference is made up
on the statement we have earnings from investments.

COMMISSIONER FIRESTONE: I don't want
to now down closer than one cent. I am concerned with
the principle. If people obtain a dollar from your
carrier they would be getting a much better deal than
from other commercial carriers paying only 40 to 50 cents?

MR. JENNER: I think that is true.

COMMISSIONER FIRESTONE: To come to
another question: if the Province of Alberta were to
decide to embark on a provincial medical care insurance
plan on a voluntary basis and they approached M.S.I.
whether they would be prepared to administer such a pro-
gram for the province, would M.S.I. be prepared to
administer such a plan?

MR. JENNER: Yes.



COMMISSIONER FINESTONE: Therefore, any

one requiring a policy from your association gets a
much better deal than from those carriers that only pay
out 40 or 50 cents.

DR. SCHMIDT: That is previously

stated.

THE CHAIRMAN: The doctors may get a

better deal.

COMMISSIONER FINESTONE: It is

insurance company pays out 40 or 50 cents out of a dollar
received the doctors will be receiving less out of the
dollar than if they get 50. Are they getting 50? Yes.
Yes?

DR. SCHMIDT: Yes.

MR. JAMIESON: The difference is made up
on the statement we have earnings from investments.
COMMISSIONER FINESTONE: I don't want

to row down either that one or the other. I am concerned with
the principle. If people obtain a dollar from your
carrier they would be getting a much better deal than
from other commercial carriers paying only 40 to 50 cents

MR. JAMIESON: I think that is true.

COMMISSIONER FINESTONE: To come to

another question: In the Province of Alberta were to
decide to embark on a provincial medical care insurance
plan on a voluntary basis and they approached M.S.I.,
whether they would be prepared to administer such a pro-
gram for the province, would M.S.I. be prepared to

administer such a plan?

MR. JAMIESON: Yes.



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COMMISSIONER FIRESTONE: Now, sir, if then at a later stage the Province of Alberta were to conclude that it wished to expand that plan into further areas or into the area of prepaid dental services, would it be possible to expand M.S.I. to cover it under a separate division?

DR. SCHMALTZ: Under our present Act, no. Presumably if the Provincial Government wished us to be their carrier and saw fit to expand the program they would also see fit to either amend the Act or give us a new one.

COMMISSIONER FIRESTONE: I would presume that would be taken care of. They would consult you. They like to consult with people. What would your answer be if you were consulted?

DR. SCHMALTZ: Yes.

COMMISSIONER FIRESTONE: The answer would be yes. If they also wanted to expand to a prepaid drug program would your answer still be yes?

MR. JENNER: That is a little more difficult. I don't know whether we can say anything without consulting the Board. That really has never been discussed. The dental thing has come up.

COMMISSIONER FIRESTONE: In other words, you would consider it when a request was received?

DR. SCHMALTZ: Yes.

COMMISSIONER FIRESTONE: If I may turn for a moment to paragraph 21 on page 6. You refer there to periodic health examinations and you mention that they are not included under your comprehensive coverage. Is



then at a later stage the Province of Alberta were to
conclude that it wished to expand their dental services, would
it be possible to expand N.D.P. to cover it under a
separate division?

DR. SCHMIDT: Under our present Act,
no, presumably if the Province Government decided to
be their center and saw fit to expand the program they
would also see fit to either amend the Act or give us a
new one.

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COMMISSIONER FRASER: If I may turn
for a moment to paragraph 21 on page 6. You refer there
to periodic health examinations and you mention that they
are not included under your comprehensive coverage. Is



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that correct? Is my understanding correct?

DR. SCHMALTZ: Yes, they are not included, no.

COMMISSIONER FIRESTONE: Would you not feel a comprehensive plan should include periodic health examinations, particularly for people over 40 and there are going to be more over 40 or 50.

DR. SCHMALTZ: That is one point that has been considered more than once. We have never been able to get anybody, including the profession, to set down the standards of what a periodic health examination is, whether it should be monthly, six-monthly; whether it should be people over 50 or under 20.

Everybody has a different idea. Everywhere you go you get a different one. We can't assess it. When somebody says what it should be, an expert opinion, we can decide.

COMMISSIONER FIRESTONE: Do I understand this matter has been discussed and there has been expression of the viewpoint of being in favour of the principle, but you have found it difficult to apply the principle because you couldn't work out a generally acceptable definition?

DR. SCHMALTZ: That is correct.

COMMISSIONER FIRESTONE: You are in agreement with the principle it would be desirable to include in a comprehensive medical health plan, a periodic examination?

DR. SCHMALTZ: The Board looks on it favourably, one of the things we should get into.



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that correct? Is my understanding correct?

DR. SCHWARTZ: Yes, they are not

included, not

COMMISSIONER TIRRETT: Would you not

feel a comprehensive plan should include periodic health
examinations, particularly for people over 50 and years
are going to be more over 50 or 55.

DR. SCHWARTZ: That is one point that

has been considered more than once. We have never been
able to get anybody, including the profession, to set
down the standards of what a periodic health examination
is, whether it should be yearly, semi-annually, whether
it should be people over 50 or under 50.

Everybody has a different idea. Every

where you go you get a different one. We can't agree to
When somebody says what it should be, an expert opinion,
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COMMISSIONER FIRESTONE: It is a matter of working out the mechanism, formula and the premium?

DR. SCHMALTZ: That is right.

COMMISSIONER FIRESTONE: This matter is under consideration?

DR. SCHMALTZ: Yes.

COMMISSIONER FIRESTONE: Do you expect some action to be taken in the foreseeable future?

MR. WHITE: Yes, we are continually discussing it.

COMMISSIONER FIRESTONE: It is most encouraging to discuss it continually, but presumably some time this discussion will come to a point where you can say yes or no?

MR. WHITE: It is lack of information.

COMMISSIONER FIRESTONE: I am turning now to paragraph 27 on page 7 where you speak of limitations in the contracts relative to full specialists' services. I am just wondering whether you can relate that phrase on the second line of page 8, "luxury service". Does that mean if somebody requires a specialist or is referred by his family doctor to a specialist that you consider this a luxury service?

DR. SCHMALTZ: No sir.

COMMISSIONER FIRESTONE: I would like to understand this term, what do you mean?

DR. SCHMALTZ: That is not considered a luxury. That is not implied in that term.

COMMISSIONER FIRESTONE: What is covered



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COMMISSIONER FIRESTONE: Do you expect

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tions in the contracts relative to full specialists'

services. I am just wondering whether you can relate

that phrase on the second line of page 8, "luxury

service". Does that mean if somebody requires a special

or is referred by his family doctor to a specialist that

you consider this a luxury service?

DR. SCHMIDT: No sir.

COMMISSIONER FIRESTONE: I would like

to understand this term, what do you mean?

DR. SCHMIDT: That is not considered

a luxury. That is not included in that term.

COMMISSIONER FIRESTONE: When is cover



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3 by what is here, put in quotation marks, I may say,
4 under "luxury services"?

5 DR. SCHMALTZ: There are some indivi-
6 duals who won't be seen going to a general practitioner
7 no matter what the condition is because a specialist is
8 a man of prestige. They may even bother the specialist
9 to the extent where they demand excessive service and
10 that is what is implied in luxury service.

11 COMMISSIONER FIRESTONE: Well, sir,
12 if the wife of one of your subscribers is pregnant and
13 she goes to her family doctor and he is elderly and he
14 says, "I haven't been doing this type of work for some
15 time" and refers her to what is called a specialist,
16 would that be covered to the full extent by M.S.I.?

17 DR. SCHMALTZ: That case will be
18 covered to the full extent of the schedule of fees
19 published by the College of Physicians and Surgeons.
20 If this specialist wished to make any additional charge,
21 because of his specialist status, he would have the
22 liberty of doing so by prior arrangement with the patient.

23 COMMISSIONER FIRESTONE: Is the answer
24 that you are paying a fee that is below what the specialist
25 would, as a rule, require for the rendering of this type
26 of service?

27 DR. SCHMALTZ: In this particular type
28 of service that may be true, in this particular service.

29 COMMISSIONER FIRESTONE: Are there
30 cases where this would also be true, where the services
of the specialist are somewhat higher or a great deal
higher than the fee schedule provided and entered into



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by what is here, but in quotation marks, I may say,

DR. SCHMALLER: There are some individuals

guarantee who won't be seen going to a general practitioner no matter what the condition is because a specialist is a man of prestige. They may even bother the specialist to the extent where they demand excessive service and that is what is implied in luxury service.

COMMISSIONER FURSTENBERG: Well, sir,

if the wife of one of your subscribers is pregnant and she goes to her family doctor and he is elderly and he says, "I haven't been doing this type of work for some time" and refers her to what is called a specialist,

would that be covered to the full extent by M.S.I.?

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because of his specialist status, he would have the

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of service that may be true, in this particular service,

COMMISSIONER FURSTENBERG: Are there

cases where this would also be true, where the service

of the specialist are somewhat higher on a great deal

higher than the fee schedule provided and entered into



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3 with M.S.I.?

4 MR. WHITE: Isn't it because if
5 some specialists' services are - they charge more for
6 their services than other specialists who may be adequate
7 or more than adequate.

8 DR. SCHMALTZ: I think part of the
9 answer, Professor Firestone, is this: I think it was
10 mentioned or, at least, referred to in the presentation
11 by the profession yesterday, the schedule of fees of the
12 Province of Alberta is drawn up with general procedures
and special procedures.

13 It must be remembered those under
14 special procedures are procedures ordinarily considered
15 to be done, should be done, by a specialist or by a
16 general practitioner with special qualifications because
17 of practice or experience.

18 The schedule that is drawn up in
19 special procedures has been, in fact, drawn up by the
20 specialists in that particular field and approved and
21 published, and this case where the special procedure is
published we pay according to that same schedule of fees.

22 COMMISSIONER FIRESTONE: In other
23 words, what you are saying, it is only if the specialist
24 charges more than the fee that is considered appropriate
25 by the profession itself that the patient would have to
pay extra?

26 DR. SCHMALTZ: The fee that is
27 published by the profession in their schedule of fees.

28 COMMISSIONER FIRESTONE: In their
29 schedule of fees. Would you feel that the burden placed
30



MR. ALLEN: I am not sure if

some specialists' services are - they charge more for

their services than other specialists who may be available

at a lower cost.

mentioned and at least referred to in the presentation

by the profession yesterday, the necessity of some of the

provisions of Alberta is drawn up with great care

and special provisions

it must be recognized that a

to be done, should be done, by a specialist or by a

general practitioner with special qualifications, whether

of practice or experience

The committee that is drawn up in

special provisions has been, in fact, drawn up by the

specialists in that particular field and approved and

confirmed, and this case where the special provisions is

submitted we pay according to that same schedule of fees

now, what you are saying, it is only if the specialist

charges more than the fee that is considered reasonable

by the profession itself that the patient would have to

DR. ALLEN: The fee that is

published by the profession in their schedule of fees.

schedule of fees. Would you feel that the current schedule



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3 on the subscribers in having to pay these extra payments
4 is substantial or rather minor?

5 DR. SCHMALTZ: It is minor.

6 COMMISSIONER FIRESTONE: Minor. Thank
7 you very much, sir.

8 THE CHAIRMAN: Dr. Baltzan.

9 COMMISSIONER BALTZAN: I want to take
10 you along, Dr. Schmaltz, referring you to page 3, para.
11 10. Following Dr. Firestone's remarks, I want a little
12 further elaboration: when the participating member gets
13 the service of a specialist directly, that is he is not
referred.

14 DR. SCHMALTZ: He is not referred.

15 COMMISSIONER BALTZAN: "In a specialty
16 condition which is within the specialty of such specialists
17 the corporation assumes the charge for the first house
18 call on the basis of the most recent schedule of fees as
19 set out by the College". Does he get a specialist fee
20 for the call or does he get a specialist fee if the
patient goes to see that specialist?

21 DR. SCHMALTZ: He gets a specialist
22 fee.

23 COMMISSIONER BALTZAN: It must be
24 within his field?

25 DR. SCHMALTZ: It must be within his
26 field.

27 COMMISSIONER BALTZAN: If the pain is
28 in the left side of his chest and it is not heart and it
is not lung but a broken rib, who pays the shot?

29 DR. SCHMALTZ: We don't police that
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on the subscribers in having to pay these extra payments
is substantial or rather minor?
DR. SCHWARTZ: It is minor.

THE CHAIRMAN: Dr. Balfour.
COMMISSIONER SALTMAN: I want to take
you along, Dr. Schwartz, referring you to page 8, para.
further elaboration: when the participating member gets
the service of a specialist directly, that is he is not

DR. SCHWARTZ: He is not referred.
condition which is within the specialty of such specialist
the corporation assumes the charge for the first house
call on the basis of the most recent schedule of fees as
set out by the "College". Does he get a specialist fee
for the call on days he get a specialist fee if the
patient goes to see your specialist?

within his field?
field.
COMMISSIONER SALTMAN: If the pain is
in the left side of the chest and it is not heart and it
is not lung but a broken rib, who pays the shot?
DR. SCHWARTZ: We don't believe that



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3 quite as accurately. If he goes to the obstetrician
4 instead of the orthopaedic surgeon for a broken leg,
5 it is an obvious thing.

6 COMMISSIONER BALTZAN: Now, I am not
7 going to belabour this question of luxury service, but
8 I ask you, Dr. Schmaltz, most people today take their
9 babies and children to a pediatrician from the start to
10 14, 15 years of age.

11 DR. SCHMALTZ: Correct.

12 COMMISSIONER BALTZAN: Do you then
13 want to reverse that trend?

14 DR. SCHMALTZ: No sir.

15 COMMISSIONER BALTZAN: It is the
16 people's choice. Medicine has so advanced pediatrics,
17 and you have that faith in pediatricians, they train
18 themselves for that purpose.

19 DR. SCHMALTZ: That is correct.

20 COMMISSIONER BALTZAN: And confidence
21 is now in the people for their children.

22 DR. SCHMALTZ: Correct.

23 COMMISSIONER BALTZAN: And no provision
24 is made to accept that responsibility.

25 DR. SCHMALTZ: Dr. Baltzan, we will
26 take the case of pediatrics, whatever is listed in the
27 schedule of fees they will get. There is a section on
28 pediatrics.

29 COMMISSIONER BALTZAN: I hope you
30 don't think I am here now participating in the interests
and on behalf of specialists.

DR. SCHMALTZ: That is correct.

quite as accurately. It goes to the other end
instead of the orthopedic surgeon for a broken leg,
it is an obvious thing.

COMMISSIONER BALTUS: Now, I am not
going to belabor this question of luxury services, but
I ask you, in general, how do you feel about
babies and children? A pediatrician from the state to
14, 15 years of age.

COMMISSIONER BALTUS: Now you will

have to answer that question.

DR. SCHMIDT: No sir.

COMMISSIONER BALTUS: It is for

people's choice. Medicine has so advanced medicine,
and you have that faith in pediatricians, they train
themselves for that.

is now in the process for their children.

DR. SCHMIDT: Correct.

COMMISSIONER BALTUS: And no provision

is made to accept that responsibility.

DR. SCHMIDT: Dr. Baltus, we will

take the case of pediatricians, whatever is listed in the
schedule of fees they will get. There is a section on
pediatricians.

DR. SCHMIDT: I hope you

don't think I am here now participating in the discussion
and on behalf of specialists.

DR. SCHMIDT: That is correct.



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COMMISSIONER BALTZAN: For the people's demands and requirements, I quote:

"For these reasons" - this is on page 8 -
"we believe that a financial barrier to unrestricted use of specialist care by the public is desirable".

You, of course, recognize it has been the custom in North America for the last two or three hundred years that people have their choice to go wherever they want and to whosoever they consider a specialist and here you say that a barrier should be put on that.

DR. SCHMALTZ: I think, Dr. Baltzan, the statement you have read...

COMMISSIONER BALTZAN: I hope it is not out of context.

DR. SCHMALTZ: ...must be taken in the context of the entire paragraph.

COMMISSIONER BALTZAN: All right.

DR. SCHMALTZ: We refer to the luxury services. We are referring to these areas of practice where there is no distinction between what is the general practitioners' field, the overlapping areas.

COMMISSIONER BALTZAN: Who is to judge that, Dr. Schmaltz? The patient, the general practitioner or the specialist?

DR. SCHMALTZ: Our contention...

COMMISSIONER BALTZAN: Or do you?

DR. SCHMALTZ: We feel that this is - the doctor is the one that could judge. The physician could be the one that could judge that.

COMMISSIONER BALTMAN: For the people's

demands and requirements. I quote:

"For these reasons" - this is on page 8

"we believe that a financial barrier

to unrestricted use of specialist care

by the public is desirable".

For, of course, recognize it has been

the custom in North America for the last two or three

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COMMISSIONER BALTMAN: All right.

DR. SCHMIDT: We refer to the luxury

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where there is no distinction between what is the

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COMMISSIONER BALTMAN: Who is to judge

that, Dr. Schmidt? The patient, the general practitioner

or the specialists?

DR. SCHMIDT: Our contention...

COMMISSIONER BALTMAN: Or do you?

the doctor is the one that could judge. The physician

could be the one that could judge that.



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4 COMMISSIONER BALTZAN: If a patient
5 goes to a specialist he should say "You should go to
6 the general practitioner"?

7 DR. SCHMALTZ: Not necessarily.

8 COMMISSIONER BALTZAN: What should he
9 say?

10 DR. SCHMALTZ: We accept the responsi-
11 bility for all other services as listed in the schedule
12 of fees but the additional billing, Dr. Baltzan. The
13 specialist may say - for example, the internist may say
14 it is perfectly all right, but my subsequent office call
15 are \$5 instead of the \$3, whatever the schedule of fees
16 happens to show.

17 COMMISSIONER BALTZAN: For the original
18 service.

19 DR. SCHMALTZ: The original service he
20 is paid his fee.

21 COMMISSIONER BALTZAN: Lastly, Dr.
22 Schmaltz, and I am not being critical - I am inquiring;
23 how do the people, the patients, and how do the
24 specialists regard this extra billing? Who does the
25 most squawking, or does anybody?

26 MR. JENNER: I am informed that we
27 have some complaints mainly in the field of obstetrics.

28 DR. SCHMALTZ: We do have some
29 complaints about extra billing as far as - if you say
30 squawking - it comes from the public, and in nearly
every instance it is because there is a failure on the
part of the specialist to adequately inform the patient
or make this prior arrangement to which the physician



COMMISSIONER BARTMAN: Is a patient

goes to a specialist he should say "You should go to the general practitioner?"

COMMISSIONER BARTMAN: What should he

says?

DR. SCHWARTZ: We accept the responsibility

for all other services as listed in the schedule of fees but the additional billing, Dr. Bartman, the specialist may say - for example, the internist may say it is entirely all right, but my assessment of the case is \$5 instead of the \$3, whatever the schedule of fees happens to show.

COMMISSIONER BARTMAN: For the original

DR. SCHWARTZ: The original service he

is paid his fee.

Schwartz, and I am not being critical - I am inquiring how do the people, the patients, and how do the specialists regard this extra billing? who does the most speaking, or does anybody?

DR. SCHWARTZ: I am informed that we

have some complaints mainly in the field of obstetrics, DR. SCHWARTZ: We do have some

complaints about extra billing as far as - if you say

speaking - it comes from the public, and in nearly every instance it is because there is a failure on the part of the specialist to adequately inform the patient or make this prior arrangement to which the physician



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has agreed in his professional agreement.

COMMISSIONER BALTZAN: Have you encountered a failure on the part of the family physician not to refer a required patient for a special procedure?

DR. SCHMALTZ: No, I have never had a complaint, not to my knowledge.

COMMISSIONER BALTZAN: People don't complain to you about that?

DR. SCHMALTZ: Of not being referred.

THE CHAIRMAN: Gentlemen, this discussion could go on ad infinitum. What has it got to do with this Commission?

COMMISSIONER BALTZAN: Only, sir, if I may sir, it wasn't anything more than to bring up the possibility of eventually giving the total coverage by including...

THE CHAIRMAN: Well, if M.S.I. is ready to accept all risks covering all the costs - what do you say, Mr. Jenner?

MR. JENNER: Not yet, no.

THE CHAIRMAN: Do you pay any commission on procurement of business?

MR. JENNER: No sir.

THE CHAIRMAN: What about medically uninsurables, people with pre-existing conditions? Are you now accepting them?

DR. SCHMALTZ: There is no such thing in our vocabulary as far as our plan is concerned.

THE CHAIRMAN: What about mental illness?

DR. SCHMALTZ: I would refer you, sir...



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THE CHAIRMAN: Just tell me.

DR. SCHMALTZ: We accept mental illness.

THE CHAIRMAN: With any restrictions?

DR. SCHMALTZ: On the individual contract there is one year's waiting period from the effective date of the contract.

THE CHAIRMAN: He is medically uninsurable for a year?

DR. SCHMALTZ: For that particular condition, yes.

COMMISSIONER VAN WART: Payroll deductions?

MR. JENNER: Do we have payroll deductions?

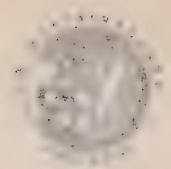
COMMISSIONER VAN WART: For mental cases.

DR. SCHMALTZ: In a group contract there is payroll deduction. There is no year's waiting period on this.

COMMISSIONER VAN WART: No waiting period.

DR. SCHMALTZ: Only on the individual contract.

COMMISSIONER McCUTCHEON: An argument we have heard from the medical profession was any scheme that might be established that no third person should stand between the patient and the doctor. I am curious of the view of the medical profession with regards that paragraph numbered 5 under sub-section 6 of your Non-Group Service Plan contract, Group C:



THE CHAIRMAN: Just tell me.

DR. SCHWARTZ: He except mental illness.

THE CHAIRMAN: With any restrictions?

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COMMISSIONER WILLIAMS: Payroll deduction

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DR. SCHWARTZ: Do we have payroll deduction

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"The appending medical practitioner
may be required to obtain the authoriza-
tion of the Director of Medical
Services of the corporation before:
1. Undertaking any long or unusual
course of treatment.
2. Referring patients for x-ray
treatment and x-ray examination except
for acute traumatic emergencies.
3. Arranging special clinical labora-
tory investigations.
4. Arranging consultations.
5. Undertaking major surgery except
in emergencies".

Isn't that direction of the type of
service the physician will be rendering to his patient?

MR. JENNER: I would have to have Dr.
Schmaltz answer that.

COMMISSIONER McCUTCHEON: Let Dr.
Schmaltz answer that.

DR. SCHMALTZ: The reason for those
clauses is in the case where abuse appears to be abuse
by the physician of the program. That is the only
reason for it.

COMMISSIONER McCUTCHEON: I understand.

DR. SCHMALTZ: Over-utilization by a
physician.

COMMISSIONER McCUTCHEON: So, you then
tell that physician that he must not thereafter do
certain things without your consent. Supposing he does



"The attending medical practitioner

may be required to obtain the authoriza-

tion of the Director of Medical

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that? What happens to the patient? Do you cover the patient?

DR. SCHMALTZ: We cover the patient, yes.

COMMISSIONER McCUTCHEON: What do you do about the physician?

DR. SCHMALTZ: In actual practice, we would refer the evidence and information to the College of Physicians and Surgeons for action.

COMMISSIONER McCUTCHEON: It does open an interesting question that, if you had a government scheme, the physician might have to go to the Minister of Health at times to find out what he could do for his patient.

If it is valid in your scheme, it would be equally valid in the Government's scheme?

MR. JENNER: Except we would refer any action to the profession to discipline the person. If the Minister did so, they wouldn't have any objection, I do not think.

COMMISSIONER FIRESTONE: Presumably, the Minister of Health could do the same and refer it to the medical profession?

MR. JENNER: As long as he did that, I do not think the medical profession would have any objection.

THE CHAIRMAN: Thank you, Mr. Jenner and Dr. Schmaltz and Mr. White. We are grateful to you for your attendance and for the assistance you have been to us.



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the medical profession?

DR. SCHWARTZ: As long as he did that,

I do not think the medical profession would have any

objection.

DR. SCHWARTZ: Thank you, Mr. Jenner.

and Dr. Schwartz and the others. We are grateful to you

for your attendance and for the assistance you have given

to us.



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MR. JENNER: Thank you very much, sir.
We are very happy to have appeared and we hope we have
been of some use to you.

THE CHAIRMAN: We have one more matter
to deal with this afternoon, and that is the Alberta
Podiatry Association.

--- EXHIBIT NO. 127: Submission of The Alberta Podiatry
Association.

SUBMISSION OF THE ALBERTA PODIATRY ASSOCIATION

Appearances: Dr. Frank Weinstein
Mr. Sydney Bercov

DR. WEINSTEIN: Mr. Chairman and
members of the Commission, my name is Frank Weinstein.
I am a Doctor of Podiatry and President of the Alberta
Association of Podiatrists. I would like to introduce
our counsel, Mr. Sydney Bercov, if there are any legal
questions.

In view of the late hour, I will
presume that the members of the Commission have read
this brief, and I will skip very quickly over most of
the points.

THE CHAIRMAN: You take the time you
think is necessary to make your proper presentation,
Dr. Weinstein.

DR. WEINSTEIN: Thank you, Mr. Chairman.
The main thing we are interested in getting across is on
page 1 of the brief where we say the submission of this
brief be accepted that there is in fact a substantial
need by the public and by the medical doctor for trained



MR. CHAIRMAN: Thank you very much, sir.

We are very happy to have sponsored and we hope we have been of some use to you.

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DR. WEINSTEIN: Mr. Chairman and

members of the Commission, my name is Frank Weinstein. I am a Doctor of Podiatry and President of the Alberta Association of Podiatrists. I would like to introduce our counsel, Mr. Sydney Berrow, if there are any legal

in view of the late hour, I will

point out that the members of the Commission have heard this brief, and I will also very briefly cover most of the points.

THE CHAIRMAN: You take the first

thing is necessary to make your presentation.

The main thing we are interested in getting across is on page 1 of the brief where we say the submission of this brief is accepted that there is in fact a substantial need by the public and by the medical doctor for training



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4 podiatrists working in association with the medical
5 doctor, and then two results must follow.

6 The first of these results is that
7 there must be satisfactory schools and facilities for
8 the training of podiatrists as well as research within
9 Canada in order to standardize and advance the profession
10 of podiatry within this country.

11 The second result that follows is that
12 the economic status of the podiatrist must be such as to
13 warrant the time, effort, skill and dedication required
14 in the initial training period as well as the development
15 and continuation of the practice of podiatry.

16 I think from there, Mr. Chairman, we
17 can skip down to page 8 and deal with the summary, and
18 I will read that and then if the Commission has any
19 questions I shall be only too happy to answer their
20 questions.

21 Summary

22 (a) The Podiatrist provides a health
23 service which is not provided by the medical doctor, and
24 in many more cases is provided reluctantly by the physi-
25 cian or surgeon.

26 (b) The segments of the public most
27 benefited by Podiatric services are members of the Armed
28 Forces, senior citizens, children, pregnant mothers,
29 industrial workers and labourers.

30 (c) The improvement in morale of our
senior citizens by keeping them ambulatory, as well as
relieving demand for hospital beds for these patients
with foot ailments has been proven time and again.



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podiatrists working in association with the medical
community, and these two results must follow.

The first of these results is that

there must be satisfactory schools and facilities for
the training of podiatrists as well as research within
Canada in order to standardize and advance the profession
of podiatry within this country.

The second result that follows is that
the economic status of the podiatrist must be such as to
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I think from these, Mr. Chairman, we
can skip down to page 8 and deal with the summary, and
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questions I shall be only too happy to answer them.

(a) The podiatrist provides a health
service which is not provided by the medical doctor, and
in many cases is provided reluctantly by the physician.

(b) The interests of the public must
be protected by podiatric services are members of the American
Industrial Workers and Laborers.

(c) The improvement in welfare of our
senior citizens by keeping them ambulatory, as well as
relieving demand for hospital beds for those patients
with foot ailments has been proven time and again.



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4 (d) The early diagnosis and treatment
5 of inherited or acquired foot ailments in children will
6 do much to prevent and lower the cost of such treatment
7 by the time they are adults.

8 (e) The financial savings that may be
9 effected by providing Podiatric services to Canadian
10 citizens will reduce absenteeism in industry, reduce
11 cost of lost wages, reduce incidence of amputations as
12 a result of foot injury or infection and will more than
13 compensate for the cost in supporting the establishment
14 of one or two Colleges of Podiatry in Canada that are
15 University affiliated.

16 (f) There is an urgent need for
17 research in all areas of the practice of Podiatry. A
18 college equipped with full-time lecturers, clinical and
19 laboratory facilities would do much to initiate, organize
20 and administer such a program in Canada.

21 (g) To recruit students to enter the
22 profession and remain in practice in Canada various
23 provincial and federal laws affecting the economic and
24 professional status require immediate amendment.

25 THE CHAIRMAN: Do you wish to deal
26 with your recommendations as well?

27 DR. WEINSTEIN: Yes, sir.

28 Recommendations

29 It is respectfully submitted that due
30 to the need of the public generally, and particularly
those members of the public who most require the aid of
a Podiatrist and who are least able to pay, the following
improvements must be made:

(d) The early diagnosis and treatment of inherited or acquired foot ailments in children will do much to prevent and lower the cost of such treatment by the time they are adults.

(e) The financial savings that may be effected by providing podiatric services to Canadian citizens will reduce absenteeism in industry, reduce cost of lost wages, reduce incidence of amputations as a result of foot injury or infection and will more than compensate for the cost in supporting the establishment of one or two Colleges of Podiatric Medicine in Canada that are

(f) There is an urgent need for research in all areas of the practice of Podiatry. A college equipped with full-time lecturers, clinical and laboratory facilities would do much to initiate, organize and administer such a program in Canada.

(g) To recruit students to enter the profession and remain in practice in Canada various provincial and federal laws affecting the economic and professional status require immediate amendment.

THE CHAIRMAN: Do you wish to deal

DR. WATKINS: Yes, sir.

REPORTER: ...

It is respectfully submitted that due to the need of the public generally, and particularly those members of the public who most need the aid of a podiatrist and who are least able to pay, the following improvements must be made:



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4 (a) Training - It is essential that
5 a school or college of Podiatry be
6 established in Canada to provide
7 training for Canadian students. This
8 could be done by the building of an
9 independent school as has been done
10 in many other countries. However, for
11 economic reasons, it would appear that
12 a school of Podiatry could be esta-
13 blished at an existing University in
14 Canada which would utilize the existing
15 physical facilities as well as the
16 lecturers already teaching the basic
17 sciences at the University.

18 Thus, only the specialized courses in
19 Podiatry would have to be added to the curriculum. This
20 would involve the hiring of perhaps 7 to 10 lecturers
21 for clinical supervision and the entire project, there-
22 fore, would not be expensive. It would probably be
23 advisable to establish such a school in association with
24 an existing University in the East as well as in Western
25 Canada.

26 I could add as an aside, Mr. Chairman,
27 that this is the way the Faculty of Dentistry was
28 developed at the University of Alberta. It started as
29 a school with a few lecturers and then it built up to a
30 Faculty.

The establishment of such a school
with full-time lecturers and proper laboratory facilities
would also permit for the first time in Canada, research



(a) Training - It is essential that a school or college of Podiatry be established in Canada to provide training for Canadian students. This could be done by the building of an independent school as has been done in many other countries. However, for economic reasons, it would appear that a school of Podiatry could be established at an existing University in Canada which would utilize the existing physical facilities as well as the lecturers already teaching the basic sciences at the University. Thus, only the specialized courses in Podiatry would have to be added to the curriculum. This would involve the hiring of perhaps 7 to 10 lecturers for clinical supervision and the entire project, therefore, would not be expensive. It would probably be advisable to establish such a school in association with an existing University in the East as well as in Western Canada.

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3 in the area of Podiatry.

4 (b) Facilities - it is necessary for
5 the appropriate authorities to recog-
6 nize that in the best interest of the
7 public, the Podiatrist must have
8 granted to him greater latitude and
9 wider privileges in the use of drugs
10 for which he is adequately trained and
11 the use of hospital facilities for
12 treatment and minor foot surgery.

13 (c) Legislation - The Podiatrist
14 requires legislative protection against
15 any private health scheme whether
16 sponsored by an insurance company or
17 by medical doctors which excludes
18 services performed by the Podiatrist
19 within the area of the Podiatrist,
20 for which he is trained and licensed,
21 for to do so gives the medical doctor
22 a monopoly in the area of Podiatry
23 insofar as all medical insurance policy
24 holders are affected.

25 Legislation to prevent such discrimina-
26 tion or in the event of a National Health Scheme, the
27 inclusion of Podiatrists therein is necessary.

28 In this last one I would like to say
29 this, that in the United States I think I can best answer
30 that by giving you a quotation from the largest health
plan that we know of on the North American continent
which covered 1,800,000 federal U.S.A. employees and



in the area of Podiatry.

(b) Facilities - It is necessary for the appropriate authorities to recognize what is the best interest of the public, the Podiatrist must have control of his greater facilities and wider privileges in the use of x-rays for which he is adequately trained and the use of hospital facilities for treatment and minor foot surgery.

requires legislative protection against any private health scheme whether sponsored by an insurance company or by medical doctors which excludes services performed by the Podiatrist within the area of the Podiatrist, for which he is trained and licensed, for he is the medical doctor of the foot in the area of Podiatry. Podiatrists as all medical insurance policy holders are excluded.

Legislation to prevent such discrimination or in the event of a National Health Scheme, the inclusion of Podiatrists therein is necessary. In this last one I would like to say this, that in the United States I think I can best answer that by giving you a quotation from the latest Health plan that we know of on the North American continent which covered 1,800,000 Federal U.S.A. employees and



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3 their families and involved 38 various plans.

4 The following statements are extracted
5 from the Civil Service Commission brochures for the two
6 government-wide plans. This is the government-wide
7 indemnity benefit plan, administered by Aetna Life
8 Insurance Company, Hartford, Connecticut:

9 "Doctor is a duly licensed Doctor of
10 Medicine (M.D.) or a duly licensed
11 Doctor of Osteopathy (D.O.). The
12 term includes surgeons and other
13 specialists if they meet this defini-
14 tion. A duly licensed dentist is
15 the same. He is also considered a doctor for purposes
16 of the plan of dental work and oral surgery
17 covered by the plan, and a duly
18 licensed podiatrist (chiropodist) is
19 also considered a doctor for purposes of
20 to such conditions covered by the plan.

21 Types of practitioners not specifically
22 mentioned above are not considered
23 doctors for purposes of this plan.
24 Government-wide service benefit plan,
25 administered by Blue Cross and Blue
26 Shield.

27 Physician is any Doctor of Medicine
28 (M.D.) or Doctor of Osteopathy (D.O.)
29 who is legally qualified and licensed
30 to practise medicine and perform
surgery at the time and place the
service is rendered.



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For services covered by this plan,
Doctor of Dental Surgery (D.D.S.)
and Doctors of Surgical Chiropody
(D.S.C.) when acting within the scope
of their licenses, are deemed to be
physicians.

No practitioners other than those
specified above shall be deemed to
be physicians for purposes of this
plan."

Now, this is the remarkable thing
about that plan. The rates for these plans remained
the same. There was no change in the rates. This is
one of the reasons that we believe that the podiatrist
needs legislative protection. The people come to us
after having been to physicians, under M.S.I., under
private plans, and they come to us and say "We have been
to such-and-such a doctor, and we still have the pain;
can you do something about it?" We say "Yes, we will be
happy to try". Then, they turn around and get highly
abusive and say "Why doesn't M.S.I. pay for this?"

THE CHAIRMAN: Abusive to you?

DR. WEINSTEIN: Yes. I have even gone
to the trouble of having a sign put in my waiting room
"M.S.I. does not cover podiatry services".

Despite the fact that it is staring
them in the face there in the waiting room, they become
abusive, and they feel they are paying a premium and
M.S.I. should cover it.

THE CHAIRMAN: Perhaps you should also



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law, and is the reasonable thing

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the same. There was no change in the rates. This is
one of the reasons that we believe that the population
needs a basic life protection. The people come to us
after having been to physicians, labor M.D.s, under
private plans, and they come to us and say "We have been
to end-of-the-world a doctor, and we still have the pain,
can you do something about it?" we say "Yes, we will be
happy to try. I am a physician and get highly
satisfied and say "Why couldn't I do this?"

THE CHAIRMAN: Alternative to you?

MR. STEIN: Yes. I have even been

to the trouble of having a sign put in my waiting room
"I do not cover dental services."

Despite the fact that it is strange
them in the back there in the waiting room, they become
apathetic, and then feel they are paying a premium and
M.D.s should cover it.

THE CHAIRMAN: Perhaps you should also



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3 say the address of M.S.I. is so-and-so.

4 DR. WEINSTEIN: Thank you, sir, but
5 they will not pay a commission for that.

6 When it comes to broader plans, they
7 come to me sometimes for a strain or something like that.
8 Because it is a strain, which is a vague thing --
9 because you cannot tell with a strain, particularly with
10 a housewife, and so on. It is a different thing when
11 it happens to a worker who is on a group plan. But on
12 a private plan, with an individual contract, they are
13 particularly difficult on these types, because they say
14 "Podiatry not included". They only pay to the physician.

15 Some of them are getting smart; they
16 realize it pays them to include us, and, in the U.S.,
17 there are over 87 private companies who have come around
18 to that way of thinking.

19 We have taken some to court, and they
20 are paying. In this country, the laws are not that way.

21 If we are going to have a national
22 health plan, the podiatrists must be included on the
23 basis that we are asking for legal recognition on their
24 part.

25 THE CHAIRMAN: You have a statute in
26 Alberta which provides for self-government of your
27 profession?

28 DR. WEINSTEIN: Self-government. The
29 licensing is done by a board with representations by
30 the profession.

THE CHAIRMAN: You mean in Alberta?

DR. WEINSTEIN: In Alberta, yes, sir.



any the address of M.B. is so-and-so.

OK. WEINSTEIN: Thank you, sir, but

they will not pay a commission for that.

When it comes to broader plans, they

come to me sometimes for a strain or something like that.

Because it is a strain, which is a vague thing --

because you cannot tell with a strain, particularly with

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3 There is a board appointed by the Provincial Government
4 consisting of both government nominees and nominees
5 from our Association.

6 At one time, the profession did it,
7 and then we -- I regret to say -- the Government did a
8 little horse-trading. There was a dispute about the
9 drug privileges, because the druggists claim they should
10 not honour podiatrists' prescriptions because of the
11 restriction in the Act, and they could not honour it.

12 We asked for clarification of the Act.
13 The Government said, then, we will clarify it, but we
14 want the licensing powers back. There was a little
15 horse-trading there, so we were put over the barrel.

16 THE CHAIRMAN: Is it unwieldy?

17 DR. WEINSTEIN: It is very dissatis-
18 factory.

19 As a matter of fact, some members of
20 the Board of Commissioners have just brought to our
21 attention they are personally liable if they hold up a
22 licence. The Association has recommended that government
23 take back the licensing right. You are infringing, but
24 you are dealing on professional standards there.

25 THE CHAIRMAN: Well, what are the
26 standards for admission for a licence?

27 DR. WEINSTEIN: In Alberta, sir, any-
28 body who is a graduate of a class A college -- and the
29 colleges have been inspected by two Canadian teams
30 consisting of podiatrists and a teaching member of a
medical faculty, one from the west and one from the east.

They sat in on their lectures; they



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The Government said, then, we will clarify it, but we want the licensing board. There was a little horse-trading there, so we were put over the board. THE CHAIRMAN: Is it possible? THE SPEAKER: It is very dissatis-

As a matter of fact, some members of the Board of Commissioners have just brought to our attention very seriously, indeed, if they hold up a licence, the Association has recommended that government

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3 met the faculties; they assessed the number of hours,
4 the plant and the physical facilities and they were
5 satisfied.

6 THE CHAIRMAN: Does the statute make
7 that provision?

8 DR. WEINSTEIN: Yes. That is right
9 in the regulations. They have accepted these schools
10 as Class A. Any graduate of a Class A school is accepted
11 without any further requirement other than being a man
12 who has not had his name stricken off another register.
13 In other words, of good moral character.

14 THE CHAIRMAN: Are there other schools
15 other than Class A?

16 DR. WEINSTEIN: Not in the United
17 States. There are no schools in Canada. That is what
18 we are asking for.

19 THE CHAIRMAN: What it would cost to
20 establish a school alongside or as part of a medical
21 college now?

22 DR. WEINSTEIN: I believe, sir, if we
23 hired 7 or 10 men and sent them down for the best
24 training -- if you are going to start a school, you had
25 better make sure the teaching staff is qualified. You
26 would have to send them down for a minimum of one year's
27 training.

28 After that, I do not think it would
29 take much more than \$100,000. You would have to send
30 up these men and pay them for relocation. I don't care
whether you establish in Edmonton or Toronto or Vancouver;
you have to have first-class people and teaching

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3 facilities.

4 THE CHAIRMAN: How many podiatrists
5 in Alberta?

6 DR. WEINSTEIN: Eleven, sir.

7 THE CHAIRMAN: And in Canada?

8 DR. WEINSTEIN: I would say a couple
9 of hundred, but there is a tremendous need for their
10 service. People do not know we exist. They come to us
11 out of desperation after having gone the rounds. Whereas,
12 in the United States, it is an established fact. With
13 movie actresses coming to us, and giving us a plug, it
14 is becoming socially acceptable. It is a necessity.

15 When you get people coming to us for
16 our services after having been operated on, the surgeons
17 having had a crack at them, and the physiotherapists
18 having had a crack at them, and they still cannot walk.

19 They say, "What can you do?". We say,
20 "We will be glad to help you". We make a prosthesis.
21 It may be to get rid of the shortage boots for polio
22 cases, and sometimes the foot is sticking up in an equinus.

23 They come to us sometimes with the
24 most horrible shoes, probably as large as that tumbler
25 of water. We turn around and do this prosthesis and
26 make them a normal-looking pair of shoes. In other
27 words, we make it look like a normal fellow's foot that
28 fits in for a normal base of support.

29 In other cases, where they have lost
30 a toe, we make something which is like a partial which
a dentist might give. It gives them a better grip, and
a better function.



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"We will be glad to help you." We make a prosthesis.

It may be to get rid of the amputee boots for police cases, and sometimes the foot is sticking up in an awkward position. They come to us sometimes with the

most horrible ones, probably as large as that towel of yours. We turn around and do this prosthesis and make them a normal-looking pair of shoes. In other

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4 These are points the physician is not
5 concerned with. First of all, he has too many people
6 to concern himself with, and too many other things.
7 These are things that we can look after and be of real
8 service and benefit to the people.

9 For instance, let me give you an idea.
10 In New York, and I think it was in 1949, they figured
11 that the sore foot cost the United States \$600,000,000
12 yearly, and that is a fair piece of change. If you cut
13 that down to our gross national product, I think you
14 will find it pays us to have a school here, and the same
15 thing, too, with a hospital.

16 THE CHAIRMAN: Is there something you
17 care to file with us?

18 DR. WEINSTEIN: You are more than
19 welcome to have this.

20 THE CHAIRMAN: Do you think it is of
21 value to us, that we should have it?

22 DR. WEINSTEIN: Certainly, I will be
23 more than happy to let you have anything which I have
24 here.

25 COMMISSIONER FIRESTONE: What was the
26 \$600,000,000?

27 DR. WEINSTEIN: This is what they
28 estimated was the loss due to lost wages, absenteeism,
29 and foot fatigue, resulting in loss of production. In
30 other words, total net loss in the gross product.

COMMISSIONER BALTZAN: I have only to
say this, that I am very much interested, and I have
read your brief completely.

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I have no questions, but maybe you wouldn't mind if I expressed this thought: I think you have a connection with the psychiatrist. You try to give people a very good understanding by improving their feet?

8

9

DR. WEINSTEIN: I just hope a few more feel that way, sir.

10

11

12

We feel that the cost of a school would be more than compensated by the benefits by saving limbs, as well as that. It has been proven in school service in hospitals wherever they have foot clinics.

13

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THE CHAIRMAN: Have you tried to interest any of the University colleges; any medical schools?

16

17

18

DR. WEINSTEIN: I cannot say that specifically. I have not tried it here. We could not even begin to man one in this province, but there is a need on the national level.

19

20

THE CHAIRMAN: No -- but, your Association?

21

22

23

24

DR. WEINSTEIN: Our Association went this far: we went to the Municipal Officer of Health for Edmonton and suggested having a school survey and his answer was "I think the service is fine; we haven't the money".

25

26

THE CHAIRMAN: A survey of school-children?

27

28

29

DR. WEINSTEIN: That is right.

THE CHAIRMAN: Oh, you are talking about a school. For your profession -- to qualify people?

30



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DR. WEINSTEIN: I have tried that.

THE CHAIRMAN: Has your Association, on a national basis, approached any University or University college?

DR. WEINSTEIN: Yes, I believe there are negotiations in progress right now with the University of Toronto.

THE CHAIRMAN: You can understand that this Commission cannot issue a directive to a school as to what it is going to do. That is wholly provincial, and within the scope of the University.

DR. WEINSTEIN: The Commission could recommend to the Governor-General in Council that funds be made available, in which case we would certainly work with the school.

THE CHAIRMAN: It is not much use having funds available if you have not got a place in which to operate.

DR. WEINSTEIN: I believe that the National Association will be commenting on this.

THE CHAIRMAN: Very well, then. That is fair.

DR. WEINSTEIN: As a matter of fact, I cannot say officially, because I have not anything official to say ---

THE CHAIRMAN: If you have a communication with your National Association ---

DR. WEINSTEIN: The communication that I have is that there is.

THE CHAIRMAN: Something concrete -- if



DR. WEINSTEIN: I have tried that.

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DR. WEINSTEIN: The communication that I have is that there is something concrete -- if



there is anything concrete, would you give us that for our consideration?

DR. WEINSTEIN: I understand there is a foundation that is interested in helping us along that line, but this is a prime need today, beneficial legislation, beneficial drug privileges, that the people can practise and give the people a better opportunity to work, because they cannot work if their feet are bothering them.

THE CHAIRMAN: Thank you very much, Dr. Weinstein and counsel.

You will be communicating with your National Association to have this matter dealt with more realistically so far as the school is concerned; not as something nebulous, but as something practical and specific.

If you have some proposal of that kind, put it forward.

DR. WEINSTEIN: Are you talking in terms of cost?

THE CHAIRMAN: There is no use talking about a school in a void. Let us get some University to let you on the campus, if there be such a thing.

Perhaps you can get something more specific and then we will have more to go on.

DR. WEINSTEIN: Thank you, Mr. Chairman. I will pass this on.

THE CHAIRMAN: We will recess now until 9 o'clock tomorrow morning.

--- Adjournment.

ROYAL COMMISSION ON HEALTH SERVICES

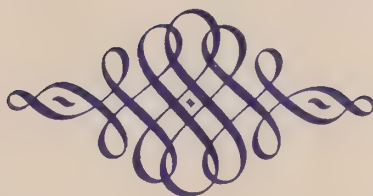
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HELD AT
EDMONTON
ALTA.

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Alberta Association of Registered Nurses

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VOLUME 25

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SUBMISSION

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1
2 ROYAL COMMISSION ON HEALTH SERVICES

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4 Proceedings of the hearing
5 held in Edmonton, Alberta,
6 Thursday, February 15, 1962.

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8 COMMISSION MEMBERS:

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10 CHIEF JUSTICE EMMETT M. HALL ----- Chairman

11 MISS ALICE GIRARD, R. N.

12 DR. DAVID M. BALTZAN

13 PROF. O. J. FIRESTONE

14 MR. M. WALLACE McCUTCHEON, Q. C.

15 DR. C. L. STRACHAN

16 DR. ARTHUR F. VAN WART

17
18 COMMISSION COUNSEL:

19 MR. R. N. HALL, Q. C.

20
21 MEDICAL CONSULTANT:

22 DR. PIERRE JOBIN

23
24 DIRECTOR OF RESEARCH:

25 PROF. BERNARD BLISHEN

26
27 SECRETARY:

28 MR. N. LAFRANCE
29
30



Proceedings of the hearing
held at Edmonton, Alberta,

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DR. DAVID M. BARTON

PROF. O. J. FLEMING

DR. M. WILSON ROBERTSON, O.C.

DR. C. L. WYBACH

DR. ARTHUR F. VAN WAGEN

COMMISSION SECRETARY:

MEDICAL CONSULTANT:

DR. FLEMING JONES

DIRECTOR OF RESEARCH:

DR. EDWARD ALLEN

SECRETARY:



Edmonton, Alberta,
Thursday, February 15, 1962.

--- ON RESUMING AT 9:00 a. m.

THE CHAIRMAN: We will now proceed with
the Submission of the Alberta Association of Registered
Nurses. This will be Exhibit number 128.

---EXHIBIT No. 128: Submission of Alberta
Association of Registered
Nurses.

SUBMISSION

of

ALBERTA ASSOCIATION OF REGISTERED NURSES

APPEARANCES:

MISS ELIZABETH BIETSCH, R. N. - Past-President of
Alberta Association
of Registered Nurses

MISS CLAUDIA TENNANT, R. N. - President of A.A.R.N.

MISS MARGUERITE SCHUMACHER, R.N. - Vice-President,
A.A.R.N.

SISTER C. LE CLERC, R. N. - Executive member of
A.A.R.N. for several
years.

MRS. MADELINE LARSON, R.N. -

MRS. HELEN SABIN, R. N. - Executive Secretary,
A.A.R.N.

ABE W. MILLER, Q. C. - Solicitor, A.A.R.N.



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- MISS MARJORIE SCHUMACHER, R. N. - Vice-President.
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- MRS. MADELINE LARSON, R. N.
- MRS. HELEN SABIN, R. N. - Executive Secretary, A.A.R.N.
- ABE W. MILLER, Q. C. - Solicitor, A.A.R.N.



1 MR. MILLER: Mr. Chairman and Members of
2 the Commission, in case any of you want to know what I
3 am doing here surrounded by so many fine looking young
4 ladies, may I say that I am, and have been for a good
5 many years, solicitor for the Alberta Association of
6 Registered Nurses. The active membership of this
7 Association is 4,660 in numbers and financially it is
8 in a good position.

9 It has, however, one striking weakness in
10 the powers of the Association - this is by way of intro-
11 duction only.

12 THE CHAIRMAN: Would you favour us by
13 introducing the charming ladies with you so we might
14 also enjoy their company.

15 MR. MILLER: I was afraid of that. Miss
16 Bietsch is Past-President of the Alberta Association
17 of Registered Nurses and a Director of Nursing in the
18 Medicine Hat General Hospital. She, along with her
19 team, prepared this brief and I will call on her to
20 introduce her team.

21 MISS BIETSCH: Mr. Chairman and Members
22 of the Royal Commission, the Committee preparing this
23 brief consisted of our President, Miss Claudia Tennant,
24 Vice-President, Miss Marguerite Schumacher, Sister LeClerc
25 who has been an Executive member and Past-Chairman of
26 finance, Miss Helen Sabin, our Executive Secretary, and
27 Mrs. Larson who has also been active in Association
28 activities.

29 MR. MILLER: With my guidance. Now,
30 there is one striking weakness in the powers of the



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MISS BIESCH: Mr. Chairman and Members

of the Royal Commission, the Committee preparing this brief consisted of our President, Miss Gladis Tennant, Vice-President, Miss Margaret Schumacher, Sister Helen who has been an Executive member and Past-Chairman of Finance, Miss Helen Sabin, our Executive Secretary, and Mrs. Larson who has also been active in Association

MR. MILLER: With my guidance. Now,

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1 Association and that is that it does not have compulsory
2 registration powers. Now, although by the act of
3 incorporation, it has disciplinary powers over its
4 members, it does not prevent a nurse who does not choose
5 to register or a registered nurse who has been suspended
6 or expelled from continuing to practice. The situation
7 is not in the best interest of the public.

8 THE CHAIRMAN: That is to practice
9 generally or to practice within a hospital or institution?

10 MR. MILLER: To practice generally.
11 Within the hospital there is a general agreement where
12 the hospital will not engage one who is not a registered
13 nurse. However, the situation is this, that the public
14 generally cannot be protected in the case from ones who
15 may become an alcoholic or a drug addict or one who is
16 dishonest. Even if a member is expelled or suspended,
17 she is not prevented from carrying on in private duty
18 nursing or in any other way whatsoever.

19 THE CHAIRMAN: Must that person have had
20 qualifications somewhere to use the title of R.N.?

21 MR. MILLER: No, there is another weakness.
22 No person can use the title of R.N. or a similar designa-
23 tion unless they are a registered nurse and graduated
24 and qualified. Now, we have run into cases, recently
25 we have had one who has had absolutely no training whatso-
26 ever and the only thing we can do if they pass themselves
27 as registered nurses is to lay a charge under the Act.
28 In one case a person was fined, I think, \$15.00 and was
29 free to continue to carry on again. As a matter of fact,
30 we have been plagued with one for the past five years who



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5 to register or a registered nurse who has been suspended
6 or expelled from continuing to practice. The situation
7 is not in the best interest of the public.
8 THE CHAIRMAN: That is to practice
9 generally or to practice within a hospital or institution?
10 MR. MILLER: To practice generally.
11 Within the hospital there is a general agreement where
12 the hospital will not engage one who is not a registered
13 nurse. However, the situation is this, that the public
14 generally cannot be protected in the case from ones who
15 may become an alcoholic or a drug addict or one who is
16 dishonest. Even if a member is expelled or suspended,
17 she is not prevented from carrying on in private duty
18 nursing or in any other way whatsoever.
19 THE CHAIRMAN: Must that person have had
20 qualifications somewhere to use the title of R.N.?
21 MR. MILLER: No, there is another weakness.
22 No person can use the title of R.N. or a similar designa-
23 tion unless they are a registered nurse and graduated
24 and qualified. Now we have run into cases, recently
25 we have had one who has had absolutely no training whatso-
26 ever and the only thing we can do is only pass themselves
27 as registered nurses is to lay a charge under the Act.
28 In one case a person was fined, I think, \$15.00 and was
29 free to continue to carry on again. As a matter of fact,
30 we have been plagued with one for the past five years who



1 has a knack of getting positions in institutions, hospitals,
2 industry and has had no training whatsoever. And now,
3 it is our information that that situation provides pretty
4 well across Canada, that is, lack of compulsory registra-
5 tion.

6 THE CHAIRMAN: That is the first time we
7 have heard it mentioned.

8 MR. MILLER: That is why I brought it
9 to your attention because it is an important thing to
10 all of us and most of the provinces do not have compulsory
11 registration, so I brought it to your attention. It will
12 be referred to in passing in the brief but I think it
13 is of prime importance that the public should be protected
14 from the charlatan, the drug addict, the alcoholic and
15 the dishonest person.

16 THE CHAIRMAN: Now, how may the public
17 be protected?

18 MR. MILLER: Compulsory registration.

19 THE CHAIRMAN: How does that prevent some-
20 body who is not entitled to registration from passing as
21 a nurse or, if we move into your profession, from passing
22 as a lawyer or doctor?

23 MR. MILLER: The same way that the medical
24 profession can suspend a member of the College of
25 Physicians and Surgeons thereby becoming disqualified
26 forever and a day until he is perhaps reinstated.

27 THE CHAIRMAN: But what prevents that
28 person who having been disqualified from going out and
29 having someone employ him?

30 MR. MILLER: By prosecution.



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MR. MILLER: By prosecution.



1 THE CHAIRMAN: Is that not open to your
2 organization now, those procedures not now open to your
3 organization?

4 MR. MILLER: As I said before only insofar
5 as we can lay a charge if they represent themselves as
6 a registered nurse. If they simply put an ad in the
7 paper: "Qualified Nurse Seeks Employment", we have no
8 argument whatsoever as long as they do not use these
9 magic initials R.N. I will now call on Miss Bietsch
10 to present the brief.

11 THE CHAIRMAN: Thank you.

12 MISS BIETSCH: Mr. Chairman, I would like
13 to read the introduction to our brief which is in essence
14 the history and activity of our Association.
15 A. The Alberta Association of Registered Nurses
16 was incorporated April 19, 1916, under The Registered
17 Nurses' Act. The active membership at that time was 12,
18 and in December, 1961, the active membership was 4,660.

19 B. The Association conducts its affairs within
20 the scope of the Bylaws, last revision of these being
21 at the time of the Annual Meeting in May, 1961. The
22 objectives as outlined in our Bylaws are:

23 (i) To maintain the honour and status of the
24 Nursing Profession.

25 (ii) To advance the educational standard of Nursing.

26 (iii) To elevate the standards of nursing practice
27 in order to render efficient service in
28 patient care.

29 (iv) To promote and regulate sound employee-
30 employer relations in the Nursing Profession.



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a registered nurse. If they simply put an ad in the

paper, "Qualified Nurse Seeking Employment", we have no

argument whatever as long as they do not use these

magic initials R.N. I will now call on Miss Bishop

THE CHAIRMAN: Thank you.

to read the introduction to the brief which is in essence

the history and activity of our Association.

A. The Alberta Association of Registered Nurses

was incorporated April 12, 1906, under the Registered

Nurses Act. The active membership at that time was 12,

and in December, 1907, the active membership was 4,000.

The Association conducts its affairs within

the scope of the bylaws. Last revision of these bylaws

at the time of the Annual Meeting in May, 1961. The

objectives as outlined in our bylaws are:

(i) To maintain the honor and status of the

(ii) To advance the educational standards of members.

(iii) To elevate the standards of nursing practice

in order to render efficient service in

(iv) To promote and regulate nursing employees

employer relations in the Nursing Profession.



1 These objectives are brought out in all our recommendations.

2 C. Schools of Nursing are under the control
3 of the University of Alberta. (See Appendix I, Exhibit
4 II). It is a privilege we are very proud of.

5 THE CHAIRMAN: Would you want to expand
6 on that, under control to what extent?

7 MISS BIETSCH: The curriculum basically
8 and the licensing examinations as well.

9 D. There are three types of membership:

10 (i) Active

11 (ii) Associate (non-practising)

12 (iii) Inactive (non-practising)

13 E. The Association is comprised of 42 Chapters,
14 the geographical distribution of which provides for
15 communication throughout the province. Each Chapter
16 functions under its own Bylaws which are approved by the
17 Executive of the Alberta Association of Registered Nurses.
18 (See Appendix II, Chapter Bylaw Guide)

19 F. The Executive of the Association is com-
20 prised of the following:

21 President

22 Three Vice-Presidents

23 Immediate Past-President

24 Chairmen of Standing Committees:

25 Committee on Employment Relations

26 Committee on Finance

27 Committee on Legislation and Bylaws

28 Committee on Nursing Education

29 Committee on Nursing Service

30 Committee on Public Relations



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- 10 (i) Active
- 11 (ii) Associate (non-practising)
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- 14 the geographical distribution of which provides for
- 15 communication throughout the province. Each Chapter
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- 22 Three Vice-Presidents
- 23 Immediate Past-President
- 24 Chairman of Standing Committees:
- 25 Committee on Employment Relations
- 26 Committee on Finance
- 27 Committee on Legislation and Bylaws
- 28 Committee on Nursing Research
- 29 Committee on Nursing Service
- 30 Committee on Public Relations



1 Advisor to the Student Nurses' Association of
2 Alberta Executive Secretary and other professional
3 personnel of Provincial Office, ex officio

4 G. J. [redacted] Due to the geographical placement of our
5 larger hospitals, and in order to maintain active com-
6 munications throughout the province, the two major Com-
7 mittees on Nursing Service and Nursing Education are divided
8 into the Southern Branch, Central Branch and Northern
9 Branch. These Branches direct all their communications
10 to the provincial committee which in turn refers all
11 recommendations to the Executive.

12 H. [redacted] We have the privilege of communications with
13 the Alberta Division of the Canadian Medical Association
14 and Associated Hospitals of Alberta through the Alberta
15 Medical-Hospital-Nursing Liaison Committee, which meets
16 approximately four times a year in the Conference Room
17 of the Provincial Office Building of the Alberta Associa-
18 tion of Registered Nurses. The objectives of this
19 Committee are stated as follows:

20 "To provide opportunities for discussing matters
21 of mutual interest and to make recommendations
22 to the participating Association."

23 All recommendations by this Committee are referred to each
24 parent organization for action.

25 I. [redacted] At present we do not have the privilege of
26 representation on the Advisory Committee to the Psychiatric
27 Nursing Group or the Planning Committee for Provincial
28 Training School Program for mentally defective which
29 prepares people as "Psychiatric Nurses". These are
30 outlined in the Appendix and we recommend bringing these



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Alberta Executive Secretary and other professional
personnel of Provincial Office, ex officio

G. Two to the geographical placement of our
larger hospitals, and in order to maintain active com-
munications throughout the province, two major Com-
mittees have been formed into the Southern Branch, Central Branch and Northern
Branch. These branches direct all their communications
to the Provincial Committee which in turn refers all
recommendations to the Executive

H. We have the privilege of communicating with
the Alberta Division of the Canadian Medical Association
and associated hospitals, and through the Alberta
Medical-Hospital-Physician Liaison Committee, which meets
approximately four times a year in the Conference Room
of the Provincial Office Building of the Alberta Associ-
ation of Registered Nurses. The objectives of this
Committee are stated as follows:

"To provide opportunities for discussing matters
of mutual interest and to make recommendations
to the participating Association."

All recommendations by this Committee are referred to each
person or persons for action

I. At present we do not have the privilege of
representation on the Advisory Committee to the Provincial
Nursing Council or the Planning Committee for Provincial
Training School Program for medical, dental and
nursing people as "Physicians' Nurses". There are
outlined in the Appendix and we recommend bringing these



1 people under the aegis of the Alberta Association of
2 Registered Nurses.

3 J. The Association has representation on the
4 following Committees of the University of Alberta:

5 (i) Committee on Nursing Education, General
6 Faculty Council

7 (ii) Board of Examiners in Nursing, General
8 Faculty Council

9 K. Nursing Recruitment is sponsored by the
10 Department of Public Health and the Director works closely
11 with the Alberta Association of Registered Nurses and the
12 Student Nurses' Association of Alberta. In addition to
13 this we have a nurse representative on the Advisory
14 Committee to Nursing Recruitment.

15 L. The Alberta Association of Registered Nurses
16 occupies its own new office building which was officially
17 opened on November 12, 1958. This was completely
18 financed by the fund of the members.

19 M. The Nursing Care Survey Committee was set
20 up by the Provincial Order-in-Council in 1959. This
21 Committee had representation from the Alberta Association
22 of Registered Nurses, Associated Hospitals of Alberta,
23 the College of Physicians and Surgeons and the Government.
24 A preliminary quantitative study of all hospitals in
25 Alberta was conducted December 10, 1959, in which the
26 quantity of care was recorded as provided by the following:
27 Graduate Nurse; Student Nurse; Certified Nursing Aide;
28 Nursing Aide Trainee; Ward Clerk; Ward Aide; Orderly.
29 This was followed by the evaluation of the quality of
30 nursing care by a team of four registered nurses, conducted



1 in selected hospitals. Hospitals with connecting Schools
2 of Nursing were not included in this study. In my
3 introduction I said this data has been completed and the
4 report is not available but since then it has become
5 available and we offer our one and only precious copy
6 as an Exhibit. I am quite certain you will be able to
7 obtain additional copies from the Minister. This is
8 our own copy since we had representation on the Committee.

9 THE CHAIRMAN: It contains information
10 of the survey?

11 MISS BIETSCH: Yes.

12 THE CHAIRMAN: We will have copies made
13 and return your copy to you in due course if that is the
14 only way it can be handled.

15 MR. MILLER: It could be obtained from
16 the Department of Health.

17 THE CHAIRMAN: Then our Secretary will
18 do that.

19 MISS BIETSCH:
19 None. The interest stimulated by the preparation
20 of this Brief was most gratifying. A total of eighteen
21 submissions were received, these being representative of
22 provincial committees, branches of committees, faculties
23 of Schools of Nursing, and Chapters. Representation on
24 the committees was from Nursing Service, Nursing Education,
25 Public Health Nursing and the smaller municipal hospitals.
26 The Task Committee appointed to prepare the Brief reviewed
27 all submissions and included all major recommendations in
28 this compilation. (See Appendix III)

29 Our recommendations from 17 different
30 groups throughout the Province, from these we selected



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2 introduction I said this data had been completed and the
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4 available and we often ask you and any previous copy
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6 obtain additional copies from the Minister. This is
7 our own copy since we had representation on the Committee.
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1 all the major recommendations which we felt may be pre-
2 sented to the Royal Commission. The additional re-
3 commendations will be referred to the provincial committees.
4 With your permission I would, rather than reading our
5 recommendations, like to highlight them.

6 THE CHAIRMAN: Would you find it more
7 convenient to have discussion on each recommendation as
8 you outline it or after you have given us the summary?

9 MISS BIETSCH: I would sooner present the
10 summary and then go back to each recommendation.

11 THE CHAIRMAN: Very well.

12 MISS BIETSCH: We are primarily concerned
13 with the quality of nursing care as set out in recommenda-
14 tion one. By quality of nursing care we mean that level
15 of care which meets the patient's needs, physical, emotional,
16 spiritual, at each level as the patient moves from de-
17 pendent to independent functions in his return to health,
18 and that a safe ratio of professional to auxiliary per-
19 sonnel be maintained in order to provide total patient
20 care at all times. We recommend that the quality of
21 nursing care be conducted solely by the needs of the
22 patient and not by budgetary restrictions. The increase
23 in the numbers of auxiliary personnel employed in
24 hospitals is not caused by the inability to obtain pro-
25 fessional personnel in order to meet the physical needs
26 of the patient and still remain within the confines of
27 the budgetary allocation of the hospital. The nursing
28 administrators are forced to employ people who can give
29 the physical care and thus leave the tangible needs of
30 the patient. As outlined in our Brief, for 1960 to 1961,



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recommendations, like to highlight them.
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convenient to have discussion on each recommendation as
you outline it or after you have given us the summary?
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the patient. As outlined in our Brief, for 1966 to 1967.



1 there is a decrease of 14% in professional personnel and
2 an increase of 42.2% in auxiliary personnel, and the
3 increase in active hospital beds was 129 compared to
4 50 in the auxiliary hospital beds.

5 It is the responsibility of the nursing
6 profession to assess and identify nursing problems and
7 to take necessary action to remove these. One important
8 factor in preventing the optimum quality of nursing care
9 is that these services are provided by personnel who
10 meet and maintain the professional requirements of our
11 Association. Since we do not have mandatory registration
12 in our Province it is difficult to insure that nursing
13 care is given by people who are qualified to practice.
14 We cannot take disciplinary action if they violate the
15 code of ethics. They may still remain after disciplinary
16 action. The nurse must also feel secure financially
17 and employers should be under the obligation to help the
18 nurses advance in their professional preparation. There
19 is little being done to prepare the nurses for leadership
20 as a team leader or head nurse or administrator. There
21 is no budget appropriation for in-service preparation
22 which includes attendance at workshops. These are
23 covered by the Federal - Provincial training grant. The
24 Alberta Association prepares personnel problems and these
25 are very intelligently voted on at the Annual Meetings,
26 and we have the task of interpreting these to our em-
27 ployers. However, in the meantime, the associated
28 hospitals of Alberta in their present policy have re-
29 commendations which they feel will meet their budgetary
30 requirements based on the increase in the hospital grant,



an increase of 42.2% in auxiliary personnel, and the increase in active hospital beds was 12% compared to 50 in the auxiliary hospital beds.

It is the responsibility of the nursing

profession to assess and identify nursing problems and to take necessary action to remove these. One important factor in providing the optimum quality of nursing care

is that these services are provided by personnel who

meet and maintain the professional requirements of our

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in our Province it is difficult to insure that nursing

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hospitals of Alberta in their present policy have re-

commendations which they feel will meet their budgetary

requirements based on the increase in the hospital grant.



1 so consequently if we raise our policies by 5% the
2 Government grant is only going to be increased 3%.

3 In addition to this we had no pension
4 plan for nurses and the associated hospitals of Alberta
5 has presented the plan to the Minister of Health which
6 will be portable throughout the Province of Alberta. I
7 hope that if I am wrong in this I will be corrected, that
8 this does not cover married nurses.

9 A survey done by the
10 Canadian Nurses Journal in the June 15th, 1961, shows
11 in Alberta we have 52.4% married nurses in active nursing.
12 We have several copies of this for you, if you wish, sir.
13 For public health the co-ordination of the services
14 is lacking, advisory services are lacking and we are
15 not utilizing these services to the fullest benefit of
16 the patient because each health unit is autonomous
17 in its administration, which means there is no uniformity
18 throughout the Province.

19 We have 12 schools of nursing. We feel
20 that these schools are showing excellent
21 performances in preparing these student nurses for
22 practice. The test pool examinations are one criterion
23 we use in evaluating our progress. There are seven
24 provinces in Canada using these. Out of 54 jurisdictions,
25 Alberta in 1960 was fifth in medical nursing, fourth
26 in surgical nursing, third in obstetrical nursing,
27 seventh in nursing of children and tenth in psychiatric
28 nursing. Following this arrangements were made to
29 provide affiliation in psychiatric nursing for all the
30 students by making the services of the medical institutes



1 available to the Schools of Nursing.

2 However, we do not think enough is done
3 to encourage students to prepare themselves for leader-
4 ship following basic preparation. . . . Therefore we have
5 outlined a plan which will prepare the graduate nurses
6 for public health nursing, nursing service administration
7 or nursing education in a four year period. . . In addition
8 to this the students in the 12 nursing schools, providing
9 the University academic requirements are fulfilled will
10 also be eligible for this advanced preparation. . . In
11 addition we hope to enhance the program for the psychiatric
12 nurses and also to give them an opportunity to prepare
13 themselves for leadership.

14 As we mentioned before, all of our schools
15 in the Province do ~~come under the control of the~~
16 University of Alberta as far as curriculum and professional
17 licensing is concerned. This we wish to maintain
18 especially since at the last revision of hospital re-
19 gulations the clause was inserted that the Lieutenant-
20 Governor by order-in-council has the authority to open
21 Schools of Nursing in the Province of Alberta. Previously
22 this authority was direct from the University. We feel
23 that all of the professional personnel as well as the
24 Certified Nursing Aide should come under the administra-
25 tion or aegis of the Alberta Association of Nurses.
26 We feel too that the vocational schools which are
27 already in existence and which are going to be built
28 within the next year or two, should be utilized for the
29 purposes of housekeeping personnel, the orderlies,
30 ward clerks, ward aides, et cetera. . . We have asked for



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2 However, we do not think enough is done

3 to encourage students to prepare themselves for leader-

4 ship following basic preparation. Therefore we have

5 outlined a plan which will prepare the graduate nurses

6 for public health nursing, nursing service administration

7 or nursing education in a four year period. In addition

8 to take the students in the 12 month schools, providing

9 the University academic requirements are fulfilled with

10 also be eligible for this advanced preparation. In

11 addition we hope to enhance the program for the baccalaureate

12 nurses and also to give them an opportunity to prepare

13 themselves for leadership.

14 At the national level, all of our schools

15 in the Province do come under the control of the

16 University of Alberta as far as curriculum and professional

17 licensing is concerned. This we wish to maintain

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19 gulations the clause was inserted that the lieutenant-

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27 already in existence and which are going to be built

28 within the next year or two, should be utilized for the

29 purpose of housekeeping personnel, the orderlies,

30 ward clerks, ward aides, etc. etc. We have asked for



1 since 1954, our records indicate, and we also asked in
2 our 1957 Brief to the Commission on Medical Services in
3 the Province of Alberta that Schools of Nursing be put
4 on a separate budget and that a cross-analysis be done
5 so far as this can be done. Schools with hospitals don't
6 receive a greater proportion than those without and it
7 is very difficult for administrators to make a decision
8 of how much to allocate to the school when the patient
9 needs are so overwhelming and nursing service, of
10 necessity, comes first. That is why our budgetary
11 request for current years are filled at the end of the
12 year, if there is any money left. If there isn't they
13 are not forthcoming unless they are very greatly needed.
14 This, sir, concludes my story of the recommendations.

15 THE CHAIRMAN: Thank you very much. Has
16 anyone else present here with you any comment or observation
17 to make at this time.

18 There was a matter you were going to file
19 some Exhibits. Mr. Lafrance is back.

20 THE SECRETARY: The main submission has
21 gone in as number 128.

22 THE CHAIRMAN: This large document, Mr.
23 Lafrance, will be 128a. It is being loaned to us so we
24 can make copies if we cannot get copies from the Department
25 of Health. Will you please identify the documents
26 for the record so they will be on the record.

27 THE SECRETARY: 128A will be the Report
28 of the Nursing Care Survey Committee, November, 1961.
29 Exhibit 128B will be the Personnel Policies approved by
30 the Alberta Association of Registered Nurses revised in



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2 our 1957 Brief to the Commission on Medical Services in
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27 THE SECRETARY: 128a will be the Report

28 of the Nursing Care Survey Committee, November, 1951.

29 Exhibit 128b will be the Personnel Policies approved by

30 the Alberta Association of Registered Nurses revised in



1 1962: 128C will be the Regulations, Government Schools
2 of Nursing in the Province of Alberta, January 1961.
3 128D will be the Alberta Association of Registered
4 Nurses' Brief to the Alberta Hospital Insurance Planning
5 Committee in 1956. 128E will be the Marital versus
6 Single, The Graduate Nurse Subscribers in Canada.

7
8 ---EXHIBIT No. 128A: Report of the Nursing Care
9 Survey Committee, November, 1961.

10
11 ---EXHIBIT No. 128B: Personnel Policies Approved
12 by the Alberta Association
13 of Registered Nurses revised
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16
17 ---EXHIBIT No. 128C: Regulations, Government Schools
18 of Nursing in the Province of
19 Alberta, January, 1961.

20
21 ---EXHIBIT No. 128D: Alberta Association of
22 Registered Nurses Brief
23 to the Alberta Hospital
24 Insurance Planning Committee
25 in 1956.

26
27 ---EXHIBIT No. 128E: The Marital Versus Single;
28 The Graduate Nurse Subscribers
29 in Canada.

30 THE CHAIRMAN: Miss Girard?

COMMISSIONER GIRARD: Miss Bietsch,
to start with the survey that you just tabled as an Exhibit,
I wonder if you could answer a few questions on it. Have
you had time to study it?

MISS BIETSCH: Briefly.

COMMISSIONER GIRARD: You said it has just



1 1962.

2 of Nursing in the Province of Alberta, January 1961.

3 1980 will be the Alberta Association of Registered

4 Nurses. Prior to the Alberta Hospital Insurance Planning

5 Committee in 1960. 1982 will be the Medical versus

6 Single. The Graduate Nurse Supervisors in Canada.

7 --EXHIBIT No. 128A: Report of the Nursing Care

8 --EXHIBIT No. 128E: Personnel Policies Approved

9 of Registered Nurses referred
10 in 1962

11 --EXHIBIT No. 128C: Regulations, Government Policies
12 of Nursing in the Province of
13 Alberta, January, 1961.

14 --EXHIBIT No. 128D: Alberta Association of
15 Nurses
16 to the Alberta Hospital
17 Insurance Planning Committee
18 in 1960.

19 --EXHIBIT No. 128F: The Medical versus Single,
20 in Canada.

21 THE CHAIRMAN: Miss Girard?

22 To start with the answer that you just asked as an Exhibit.

23 I wonder if you could answer a few questions on it. Have

24 you had time to study it?

25 COMMISSIONER GIRARD: You said it has just



1 come to you. You state here that the Survey deals with
2 the quantity of care and the evaluation of the quality
3 of care. Does this Survey go into any of the norms
4 that are currently being used or that have been used or
5 that should be used in the ratio - in the quantity of
6 nurses or the nursing hours used as making up budgets.

7 MISS BIETSCH: Mr. Chairman, this Survey
8 does not give any figures at all as recommendations.
9 It gives the present care and outlines the weaknesses
10 that were found throughout nursing care, the physical
11 plant of hospitals et cetera and recommendations regarding
12 this. There are no norms established.

13 COMMISSIONER GIRARD: It wasn't taken
14 into that.

15 THE CHAIRMAN: By what standards
16 then do you measure the need quantitatively.

17 MISS BIETSCH: The way it was measured
18 in this Survey, the four nurses went out and worked in
19 the hospitals for a period of time. I believe it was
20 a two-week period on all tours of duty and assessed the
21 care given and recommended the type of care that should
22 be given and the amount of people required to do it. In
23 some of our hospitals, we adjusted to give us something
24 basic. Many others use the American Guide for Nursing
25 Service. We changed it to meet our own needs.

26 COMMISSIONER GIRARD: Has there been any
27 kind, maybe on a small scale, any kind of study, locally
28 or provincially on this thing, on this scale, to help
29 you when you make your budget, when the Director of
30 Nursing makes her budget at the end of the year for the



1 come to you. You state here that the survey deals with

2 the quantity of care and the evaluation of the quality

3 of care. Does this survey go into any of the items

4 that are currently being used or that have been used or

5 that should be used in the future - in the context of

6 courses or the nursing course used as making of budgets.

7 does not give any figures at all as recommendations.

8 It gives the present care and outlines the suggestions

9 that were found throughout nursing care, the physical

10 plant of hospitals at present and recommendations regarding

11 this. There are no recommendations.

12 COMMISSIONER OF HEALTH. It wasn't taken

13 into that

14 THE CHAIRMAN. In preparation

15 then as you measure the need quantitatively.

16 MISS BIRTSCH. The way it was measured

17 in this survey, the four nurses went out and worked in

18 the hospitals for a period of time. I believe it was

19 a two-week period on all four of days and nights and the

20 care given and recommended the type of care that should

21 be given and the amount of people required to do it. In

22 some of our hospitals, we adjusted to give us something

23 more. Many doctors use the American Guide for Nursing

24 service. We changed it to meet our own needs.

25 COMMISSIONER OF HEALTH. Has there been any

26 kind, maybe on a small scale, or kind of study, locally

27 or provincially on this thing, on this scale, to help

28 you when you make your budget, when the Director of

29 nursing makes her budget at the end of the year for the



1 number of nursing hours which she needs, which will, in
2 turn, give us the number of personnel? That's what
3 you have been using, the National League Scale.

4 MISS BIETSCH: Amended to our own needs
5 according to the type of patients. There is nothing
6 provincially we have to follow. We have set up our own
7 pattern. That is why we are waiting for the National
8 Survey to be ready by Miss Kampy.

9 COMMISSIONER GIRARD: You said amended to
10 our own needs. Do you find they differ greatly from
11 those in the scale?

12 MISS BIETSCH: Yes, they do. In the care
13 of the newborn the hours are not adequate as mentioned
14 in the American Study. Pediatric Nursing is not
15 adequate. We feel the ratio, because of team nursing
16 we have more auxiliary personnel than the 35 as suggested.

17 COMMISSIONER GIRARD: Do you find a great
18 ratio in neurosurgical nursing and in cardiac nursing?

19 MISS BIETSCH: I will have to ask someone
20 else to speak to this?

21 MISS TENNANT: Yes, there will be a great deal
22 of variance. We have in the last few years gone into
23 cardiac nursing in many of the hospitals. Neurosurgery
24 is done very little. It wouldn't be something we have
25 a pattern of.

26 COMMISSIONER GIRARD: This has been found
27 in other places to be differing in the ratio.

28 MISS TENNANT: As far as I can say in
29 Alberta there is very little neurosurgery. Cardiac
30 nursing is not that extensive.



1 COMMISSIONER GIRARD: Do you feel it is a
2 need?

3 MISS TENNANT: Very definitely, yes.

4 COMMISSIONER GIARARD: But we really need a
5 pilot to be able to give figures that will be meaningful
6 to the administrator making the budget for nursing personnel.

7 MISS TENNANT: Yes.

8 COMMISSIONER GIRARD: Coming to the
9 mandatory registration, I want to add a word to that. I
10 believe that the majority of the nursing associations in
11 Canada have mandatory, but there I am not too sure. It is
12 my impression there are more that have it than haven't,
13 but it is a goal.

14 On page 15 you speak about the decrease
15 of professional nurses and the increase of auxiliaries
16 and there is a ratio given here. I think you mentioned
17 in the summary a decrease of 14% of professional personnel
18 in 1960 with an increase of 42% of auxiliary personnel.
19 What would be the result of this imbalanced ratio?

20 MISS BIETSCH: Mr. Chairman, we are not
21 sure, but we are inclined to think it is caused by
22 budgetary restrictions.

23 COMMISSIONER GIRARD: There is not much
24 money for nurses, so nursing aides are taken in?

25 MISS BIETSCH: They give the physical
26 care and the survey shows in a great number of our smaller
27 hospitals the nursing aide is carrying out professional
28 responsibilities even to the point where she is on duty
29 alone at nights with a matron being on call, perhaps

30 COMMISSIONER GIRARD: Has some representa-



1 need?

2 COMMISSIONER STANARD: But we really need a

3 COMMISSIONER STANARD: Coming to the

4 mandatory registration. I want to add a word to that.

5 I believe that the majority of the existing associations in

6 Canada have mandatory, but there are not too many. It is

7 my impression there are more that have it than haven't.

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9 On page 12 you speak about the decrease

10 of professional nurses and the increase of auxiliaries

11 and there is a ratio given here. I think you mentioned

12 that right, Mr. Chairman, we are not

13 ALAN BRYSON: May I give the physical

14 responsibilities over to the point where she is on duty

15 alone as of right with a station being on call, perhaps

16 COMMISSIONER STANARD: Has some representative



1 tion been made to the hospital authorities about this?

2 Are they aware, I suppose they are aware. Is this

3 accepted as being logical or normal?

4 MISS TENNANT: I don't think it is

5 accepted as being logical or normal, but it is the

6 situation that existed. It is a question of budgetary.

7 Also, in the small hospitals there is a problem of getting

8 nurses to go out to the small hospitals. We have tried,

9 the hospitals have paid more for going to the outlying

10 places, an increase in the salary for those who go,

11 but it is still not too satisfactory. There are a good

12 many of the hospitals who are expecting nursing aides

13 to carry out a lot of responsibility that should not

14 be theirs at all. They are not getting the nurses into

15 the small places when they would go. Also, they will

16 bring in nurses from other countries, European nurses

17 because they can hire them at a less salary than re-

18 gistered personnel. A nurse not eligible for Alberta

19 registration will take 85% of the salary. That is

20 satisfactory to them, they are hiring a graduate nurse

21 which is all that the Act states they must be, graduate

22 nurses. They are satisfying themselves that way and the

23 graduate nurses are carrying the full responsibility, but

24 they are not necessarily eligible for registration in

25 our Association.

26 COMMISSIONER GIRARD: You would feel this

27 is a monetary problem rather than a shortage of nurses'

28 problem.

29 MISS TENNANT: I think the monetary problem

30 is the biggest problem, yes.



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2 Are they aware, I suppose they are aware. Is this

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8 nurses to go out to the small hospitals. We have tried

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19 registration will take 85% of the salary. That is

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22 nurses. They are satisfying themselves that way and the

23 graduate nurses are carrying the full responsibility, but

24 they are not necessarily eligible for registration in

25 our Association.

26 COMMISSIONER OF LABOR: Yes, would I feel this

27 is a monetary problem rather than a shortage of nurses?

28 Is the biggest problem, yes.



1 COMMISSIONER GIRARD: On page 16 again,
2 at the bottom of page 16, paragraph 10D: "That critical
3 analysis be made of the distribution pattern of nursing
4 personnel with a view to the use of auxiliary personnel
5 in all areas of nursing". I think the background of
6 this is public health. Have you used any auxiliary
7 personnel in public health nursing - not the mounties?

8 MRS. LARSON: Not to date, auxiliary personnel
9 are not being used to my information, Miss Girard. We
10 are hoping, perhaps in visiting, the Victorian Order
11 of Nurses and so on that would have pilot care, this
12 home care problem can be developed perhaps and that type
13 of person can be used, and even in the preventive service
14 program, perhaps auxiliary personnel can be used.

15 COMMISSIONER GIRARD: Does this paragraph
16 mean that you would be willing to use auxiliary personnel?

17 MRS. LARSON: Yes.

18 COMMISSIONER GIRARD: If you haven't used
19 them it is because you don't have them or haven't started.

20 MRS. LARSON: That is correct, Miss Girard.
21 I think it is because we haven't made use of them or
22 haven't developed a program to make use of the auxiliary
23 personnel in public health.

24 COMMISSIONER GIRARD: You know the V.O.N.
25 in other provinces have made use of them in home visits?

26 MRS. LARSON: That is what we are thinking
27 about the possibility of doing now.

28 COMMISSIONER GIRARD: Would you want some
29 special training or would it be the nursing aides that
30 you have been training?



COMMISSIONER GIBSON: On page 16 again,

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in other provinces have made use of them in home visits?

MRS. LARSON: That is what we are thinking

about the possibility of doing now.

COMMISSIONER GIBSON: Would you want some



1 MISS BIETSCH: Certified nursing aides.

2 COMMISSIONER GIRARD: Would you feel that
3 certified nursing aides could be put to use by you in
4 public health nursing as they are prepared now or should
5 they be prepared differently to be able to be used ?

6 MRS. LARSON: I don't think they would be
7 prepared on the basis of their preparation, some added
8 preparation for that type of service, going into the homes
9 and working at the bed-side in the home would be needed.
10 I think there would have to be some little different
11 preparation on the basis of what they are doing now.

12 COMMISSIONER GIRARD: Are you aware that
13 the V.O.N. have used male auxiliary nurses or nursing aides?

14 MRS. LARSON: Yes.

15 COMMISSIONER GIRARD: I understand one
16 result, someone was telling me, one woman called and
17 she wanted that male auxiliary nurse because he was
18 stronger in order to lift her and help her out of her
19 bed. Maybe that is something we should look into. What
20 is the situation of male nurses in Alberta? Do you have
21 any?

22 MISS TENNANT: About half a dozen in
23 Alberta except in the mental hospitals. We have a program
24 for the male nurses in the...

25 COMMISSIONER GIRARD: Like R.N.?

26 MISS TENNANT: A three year course,
27 psychiatric nurse.

28 COMMISSIONER GIRARD: Do you approve of
29 male nurses?

30 MISS TENNANT: Yes. Our Annual Meeting last



MISS HATSON: Certified nursing aides.

COMMISSIONER GILBERT: Would you feel that

certified nursing aides could be put to use by you in

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they be prepared differently so as to be used?

MRS. LARSON: I don't think they would be

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MISS THOMAS: About half a dozen in

Illinois except in the mental hospitals. We have a program

for the male nurses in the...

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COMMISSIONER GILBERT: Do you approve of

male nurses?

MISS THOMAS: Yes. Our Annual Meeting last



1 year went on record as approving of them and also approved
2 a program to encourage males to enter the nursing pro-
3 fession.

4 COMMISSIONER GIRARD: What do you think
5 keeps them out of nursing?

6 MISS TENNANT: Status, I think.

7 THE CHAIRMAN: What about salary, income?

8 MISS TENNANT: The income does definitely,
9 and the training period itself will cause so many of
10 these young men who are of the age group and are married
11 and starting families, they certainly couldn't live on
12 it, on what the student nurse is expected to put in.
13 There are no grants available for married students going
14 income, male or female.

15 THE CHAIRMAN: It would require a different
16 type of residential accommodation and that kind of thing?

17 MISS TENNANT: Yes, but one of the re-
18 commendations we have in this Brief is that accommodation
19 be not necessarily for any student.

20 THE CHAIRMAN: You would think of having
21 an equivalent in cost?

22 MISS TENNANT: Some way of supporting
23 this man and his family while he was training.

24 COMMISSIONER GIRARD: They should live
25 out. You have recommended that you are in favour of that.

26 MISS TENNANT: Resident occupation
27 be not compulsory for any one.

28 COMMISSIONER GIRARD: That is right.
29 So, it would not be compulsory for male nurses either?

30 How far have you gone in this class of

1 You went on record as approving of them and also approved

2 a program to encourage males to enter the nursing pro-

3 fession.

4 COMMISSIONER GIBSON: Would you think

5 keeps them out of nursing?

6 MISS TENANT: Certainly, I think.

7 THE CHAIRMAN: What about salary, income?

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9 these young men who are of the age group and are married

10 and starting families, they certainly couldn't live on

11 it, on what the student nurse is expected to get in.

12 There are no grants available for married students who

13 income, male or female.

14 THE CHAIRMAN: I suppose practice is different

15 type of residential accommodation and what kind of things?

16 MISS TENANT: Yes, but one of the re-

17 commendations we have in this field - and accommodation

18 be not necessarily for any student.

19 THE CHAIRMAN: You would think of nursing

20 an equivalent in costs?

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25 MISS TENANT: Resident occupation

26 be not compulsory for any one.

27 COMMISSIONER GIBSON: That is right.

28 So, it would not be compulsory for male nurses either?

29 How far have you gone in this of late?



1 residence should not be compulsory for any one? Are
2 there any schools where students live out to a certain
3 extent? I do not mean 100%, but something around there.

4 MISS SCHUMACHER: Mr. Chairman, we do
5 have students, married students, in the schools through-
6 out the province who do live out, and I can think of one
7 instance where the student was not married but was
8 carrying home responsibilities, and she was given per-
9 mission to live out. But it is not an open clause,
10 shall we say.

11 COMMISSIONER GIRARD: So far it is done
12 on an individual basis?

13 MISS SCHUMACHER: Yes.

14 COMMISSIONER GIRARD: Only in one year,
15 or in all three years?

16 MISS SCHUMACHER: In some of these cases,
17 it has been --- for example, the student had a family
18 responsibility and lived out for her whole three years.
19 For a married student, there is usually a clause in the
20 School of Nursing which stipulates the students may be
21 married during the last six months, and if this is so,
22 the student may live out during that period.

23 COMMISSIONER GIRARD: Do you feel if this
24 were applied, would that help recruitment -- if it were
25 known that the students did not have to live in; those
26 that wished to do so, I mean? Or, would it be the
27 opposite?

28 THE CHAIRMAN: Would it inhibit?

29 MISS SCHUMACHER: I think there is a
30 mixed feeling about living in residence. With certain



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3 extent? I do not mean 1908, but something around there.

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7 instance where the student was not married but was
8 carrying home responsibilities, and she was given per-
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10 tion, we say.

11 COMMISSIONER GIBBARD: So far it is done

12 on an individual basis?

13 MISS SCHUMACHER: Yes.

14 COMMISSIONER GIBBARD: Only in one year?

15 or in all three years?

16 MISS SCHUMACHER: In some of them, yes.

17 it has been -- for example, the student had a family
18 responsibility and lived out for her whole three years.
19 For a married student, there is really a chance in the
20 School of Nursing which stipulates the student may be
21 married during the last six months and if this is so,
22 the student may live out during that period.

23 COMMISSIONER GIBBARD: Do you feel it is

24 were applied, would that have prevented -- it is well-
25 known that the students did not have to live in; those
26 that wished to do so, I mean? Or, would it be the

27 THE CHAIRMAN: Would it be the

28 MISS SCHUMACHER: I think there is a

29 mixed feeling about living in residence, which certainly



1 groups that I have met and have posed the question to
2 them, I am always amazed at how many of them say they
3 would prefer to live in a residence, particularly during
4 the first part of their education.

5 I think probably as they progress that
6 they are thinking, then, of going and establishing a
7 situation of their own so that they would be more ready,
8 but I think on the whole I am amazed that their response
9 is that they say they prefer to live in residence.

10 COMMISSIONER GIRARD: I did not mean
11 that we do away with residences and that all students
12 live out, because then, I am sure, it would curtail
13 recruitment, because if the students had to pay room and
14 board outside, it would certainly curtail it. But if
15 we still had residences, but said that those with parents
16 living in the city and who wish to live at home may do
17 so.

18 MISS BIETSCH: This recommendation was made
19 to cover the needs of the independent school which we
20 propose, and we thought of University residences, and
21 that the nursing students could occupy those, but
22 residences specifically for students in a nursing program.
23 The hospital schools will probably continue the residences
24 we already have, but it is the independent school we
25 had in mind in this, on another campus.

26 COMMISSIONER GIRARD: As we come to this
27 so-called independent school, would you like to tell us
28 something of your program for your two-year course, four-
29 year course, and how they would blend together?

30 MISS SCHUMACHER: May I just add one more



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something of your program for your two-year course, four-

year course and how they would blend together?



1 statement about the residence. Another question that
2 we have posed to students is if they would --- seeing
3 that they do enjoy living in residence -- what would
4 they think, then, of the idea in centres where they had
5 residences open for other programs, thinking in terms of
6 University, how would they like to live in a residence
7 where there were students from other professions or study
8 groups. And this, they feel, would be of great merit
9 from the standpoint it would then give them an opportunity
10 to exchange ideas with students in other professions.

11 COMMISSIONER GIRARD: Are you talking about
12 students in hospital schools now?

13 MISS SCHUMACHER: Yes.

14 COMMISSIONER GIRARD: Then, they would have
15 to pay room and board there?

16 MISS SCHUMACHER: That is right.

17 COMMISSIONER GIRARD: Would that curtail
18 your recruitment?

19 MISS SCHUMACHER: Well, yes, unless there
20 was some provision made in order to take care of it.

21 COMMISSIONER GIRARD: If somebody took care
22 of the bill?

23 MISS SCHUMACHER: That is right.

24 COMMISSIONER GIRARD: Would you like to talk
25 about your plans for your two-year program?

26 MISS SCHUMACHER: This is referred to on
27 page 47, as Appendix 11.

28 The basis on which we have made this ---
29 our belief is that we need nurses, not only from the stand-
30 point of quantity but also to take care of the leadership



1 statement about the residence. Another question that
2 we have posed to students is if they would --- seeing
3 that they do enjoy living in residence -- what would
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11 COMMISSIONER GIRARD: Are you talking about
12 students in hospital schools now?
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14 COMMISSIONER GIRARD: Then, they would have
15 to pay room and board there?
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17 COMMISSIONER GIRARD: Would that entail
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19 MISS SCHUMACHER: Well, yes, unless there
20 was some provision made in order to take care of it
21 COMMISSIONER GIRARD: If nobody took care
22 of the bill?
23 MISS SCHUMACHER: That is right.
24
25 MISS SCHUMACHER: This is referred to in
26 page 47, as Appendix II.
27 The basis on which we have made this ---
28 our belief is that we need nurses, not only from the stand-
29 point of quantity but also to take care of the leadership



1 in nursing, which we are so desperately in need of.
2 We feel that with our present programs
3 this we should continue with any modifications in order to
4 improve our educational principles and our educational
5 standards. But, on the other hand, there is also a need
6 to look at other kinds of programs to see if we can better
7 meet the needs of leadership roles.

8 We have already proven by the Canadian
9 Nurses Association that the bedside nurse can be prepared
10 in less than three years, and we are suggesting that a
11 new program not be a traditional three year pattern hospital
12 school program, but that we investigate the possibility of
13 setting up a two-year program.
14 Now, we use the term "independent" in
15 parenthesis at the present time, because we feel we
16 should study to see whether or not this should be directly
17 under the University or under the Junior College, or whether
18 it is really a separate board, with a separate budget from
19 another means.

20 COMMISSIONER GIRARD: May I interrupt?

21 MISS SCHUMACHER: Yes.

22 COMMISSIONER GIRARD: This two-year program
23 -- this nurse --- whatever you call it: clinical nurse
24 or technician. She will be a professional nurse?

25 MISS SCHUMACHER: That is correct.

26 COMMISSIONER GIRARD: She will be a R.N.
27 eventually, on graduation?

28 MISS SCHUMACHER: That is correct. So,
29 then, in pattern B, we have the two-year clinical program
30 outlined, and as we have stated here, the requirement would



in nursing, which we are so desperately in need of.

We feel that with our present programs

this we should continue with any modifications in order to

improve our educational principles and our educational

standards. But on the other hand, there is also a need

to look at other kinds of programs to see if we can better

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parenthesis at the present time, because we feel we

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it is really a separate award, with a separate board that

another means.

COMMISSIONER GIBARD: May I interrupt?

MISS SCHUMACHER: Yes.

COMMISSIONER GIBARD: This two-year program

-- this nurse -- whatever you call it, clinical nurse

in the hospital. She will be a professional nurse.

MISS SCHUMACHER: That is correct.

COMMISSIONER GIBARD: She will be a R.N.

eventually... or graduation?

then, in pattern B we have the two-year clinical program

outlined, and as we have stated here, the requirement would



1 be a University entrance requirement so that she could go
2 on then and may be given then Junior College or independent
3 school in conjunction with the hospital, but the school
4 affiliated with the University of Alberta. The University
5 of Alberta states minimum standards for our schools; but
6 the difference in this school would be that the University
7 would have the authority or would have the opportunity to
8 state that this is what will be done in detail in this
9 School of Nursing, rather than just setting minimum
10 standards.

11 of the program. COMMISSIONER GIRARD: Therefore, this
12 would be doing away with what we used to call patch-work
13 of the nurse doing so much, and wanting to get her program,
14 and taking on this and that other course?

15 request, and is MISS SCHUMACHER: That is right.

16 we might say. COMMISSIONER GIRARD: When you register
17 for the first course, they are already doing those two
18 years ---

19 THE CHAIRMAN: They must have the basic
20 University qualifications before they come in?

21 MISS SCHUMACHER: Yes, at the end of two
22 years they are graduate nurses, clinical practitioners,
23 bedside nurses.

24 COMMISSIONER GIRARD: Just as well trained,
25 or educated, if you prefer, as our three-year nurses now?

26 MISS SCHUMACHER: That is right. Then,
27 if they wish to go on, they can go back into the program
28 and take another year of study, which would they prepare
29 them for junior positions of leadership.

30 This is a great need for assistant head nurses,



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2 on then and may be given then Junior College or independent
3 school in conjunction with the hospital, but the school
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8 state that this is what will be done in detail in this
9 School of Nursing, rather than just setting minimum
10 standards.
11 COMMISSIONER GIRARD: Therefore, this
12 would be doing away with what we used to call paper-work
13 of the nurse doing so much, and wanting to get her program
14 and taking on this and that other course?
15 MISS SCHUMACHER: That is right.
16 COMMISSIONER GIRARD: When you register
17 for the first course, they are already doing these two
18 years ---
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25 or educated, if you prefer, as our three-year nurses now?
26 MISS SCHUMACHER: That is right. Then
27 if they wish to go on, they can go back into the program
28 and take another year of study, which would they prepare
29 them for Junior positions of leadership.
30 This is a great need for additional nurses



1 junior instructors, team leaders. This is the beginning
2 position in leadership roles in nursing.

3 COMMISSIONER GIRARD: Now, I am very in-
4 terested ---

5 THE CHAIRMAN: Before you leave that ---

6 COMMISSIONER GIRARD: I am not leaving
7 this, Mr. Chairman.

8 THE CHAIRMAN: Go ahead, but just before
9 you leave it, this program that you have in mind, that
10 you are speaking of, could that be made an integral part
11 of the present nursing education program? The three-
12 year course --- I take it that the University entrance
13 requirement in Alberta is grade twelve?

14 MISS SCHUMACHER: The University entrance
15 requirement is stipulated. It is a combination, I think
16 we might say, of a junior matriculation with part senior
17 matriculation courses that are necessary.

18 THE CHAIRMAN: Well now, for your entrance
19 requirement to your nursing schools today, is it less than
20 that?

21 MISS SCHUMACHER: It is less than the
22 University entrance, excepting for one school. We have
23 one in the province that does require University entrance
24 requirement, but that is all.

25 THE CHAIRMAN: How much difference is there
26 in those two standards?

27 MISS SCHUMACHER: Well, our difference is
28 with regards to over-all averages. There are some
29 differences with regards to some of the course that they
30 will be taking.



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2 position in leadership roles in nursing.
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26 in those two standards?
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28 with regards to over-all averages. There are some
29 differences with regards to some of the course that form



1 THE CHAIRMAN: That would be a matter of
2 preparation in the High School course?

3 MISS SCHUMACHER: Yes, yes.

4 THE CHAIRMAN: Guidance in the High School
5 course?

6 MISS SCHUMACHER: Yes, plus the attainment
7 of the over-all average of 60%, and in our regular Schools
8 of Nursing we do accept them with less than an over-all
9 average of 60%.

10 THE CHAIRMAN: You are talking, of course,
11 of a two-year course?

12 MISS SCHUMACHER: Yes.

13 THE CHAIRMAN: Have you any view to offer
14 on the proposition or the suggestion that we have heard
15 from time to time that the present three-year course should
16 be reduced to two; that it could be reduced to two, and
17 accomplish what the three-year course is now doing?

18 MISS SCHUMACHER: Well, the way our schools
19 are presently set up with the financial problems that we
20 have; with the difficulty of getting staff, prepared staff,
21 in some of the areas, we feel that it would not be feasible
22 to say Alberta is going into a two-year program throughout.

23 THE CHAIRMAN: That would require more
24 instructional staff to begin with?

25 MISS SCHUMACHER: Yes.

26 THE CHAIRMAN: And more time for study?

27 MISS SCHUMACHER: Yes, that is correct.

28 THE CHAIRMAN: As distinct from ward duty?

29 MISS SCHUMACHER: That is correct, and we
30 feel at the present time that, with the resistances, some



THE CHAIRMAN: That would be a matter of

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MISS SCHUMACHER: Yes, from the standpoint

of the over-all average of 60%, and in our regular schools

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of a two-year course?

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on the proposition of the suggestion that we have heard

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instructional staff to begin with.

THE CHAIRMAN: And more time for study.

MISS SCHUMACHER: Yes, that is correct.

THE CHAIRMAN: As distinct from your duty?

MISS SCHUMACHER: That is correct, and we

feel at the present time that, with the resources, some



1 of the resistances we have met, we would be wiser to go
2 into a new program and start out in that way. And, later
3 on if the other schools feel they can meet the requirements,
4 they could gradually come into the picture.

5 THE CHAIRMAN: I do not want to argue the
6 point or appear to urge another viewpoint, but if you
7 were able to bring all schools along at the same time,
8 the whole program on the one operation, you would not have
9 then two classes of registered nurses.

10 In that sense, you might obviate that
11 situation?

12 MISS SCHUMACHER: Yes, we appreciate that,
13 Mr. Chairman. But, with the obstacles that we have seen,
14 we are quite sure we could not get this point across.

15 THE CHAIRMAN: Point across with whom?

16 MISS SCHUMACHER: Well, it was mentioned
17 this morning that there has been a change in the Hospital
18 Act.

19 THE CHAIRMAN: Is it hospital management
20 you are speaking of?

21 MISS SCHUMACHER: Hospital management,
22 in part.

23 THE CHAIRMAN: Yes. Who is the other part?

24 MISS SCHUMACHER: Well, I think we have to
25 be realistic in presenting changes that we are going to
26 have a certain amount of resistance. I do not think that
27 our group as a whole --

28 THE CHAIRMAN: Is it resistance from the
29 students?

30 MISS SCHUMACHER: No, no. Well, not from



2 into a new program and start out in that way. And, I agree

3 on if the other schools feel they can meet the requirements

5 THE CHAIRMAN: I do not want to argue the

8 then two classes of registered nurses.

10 in that sense, you might observe that

11 attention?

12 MISS SCHUMACHER: Yes, we appreciate that.

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15 THE CHAIRMAN: Please across with what?

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21 be realistic in presenting changes that we are going to

22 have a certain amount of resistance. I do not think that

23 our group as a whole --

24 THE CHAIRMAN: Is it resistance from the

25 MISS SCHUMACHER: No, no. Well, not from



1 the students.

2 THE CHAIRMAN: From the nurses?

3 MISS SCHUMACHER: In some small circles,
4 they are wondering.

5 THE CHAIRMAN: Is it a financial obstacle?

6 MISS SCHUMACHER: And a financial obstacle,
7 yes. That is the big one, and then with the revision in
8 the Hospital Act that states that the Government can come
9 in and open up a school, we have been given to understand
10 that there are plans being made to open up new schools,
11 and this is our fear which we have right now.

12 THE CHAIRMAN: Well now, let us examine
13 the practical aspects for a moment.

14 How many student nurses are in training
15 in Alberta?

16 MISS SCHUMACHER: Over 1800. We have this.

17 THE CHAIRMAN: Over 1800?

18 MISS SCHUMACHER: Yes.

19 THE CHAIRMAN: And that is on the three-
20 year basis that you will graduate about 600 a year?

21 MISS SCHUMACHER: Yes. And, besides the
22 three-year program, of course we do have ---

23 THE CHAIRMAN: You have the University
24 Hospital now leading to a degree in Bachelor of Science
25 in Nursing?

26 MISS SCHUMACHER: That is right.

27 THE CHAIRMAN: Graduating how many a year?

28 MISS SCHUMACHER: This is down here --

29 I think we have ten graduating this year with Bachelor of
30 Science in Nursing.



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2 THE CHAIRMAN: From the nurses?

3 MISS SCHUMACHER: In some small circles,

4 they are wondering.

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6 MISS SCHUMACHER: And a financial obstacle.

7 Yes. That is the big one, and then with the rotation in

8 the Hospital Act that states that the Government can open

9 in and open up a school, we have been given to understand

10 that the Government is going to open up a school.

11 and I think the first step is to open up a school.

12 THE CHAIRMAN: Well now, let us examine

13 the practical aspects for a moment.

14 How many student nurses are in rotation

15 in rotation?

16 MISS SCHUMACHER: Over 1,000. We have about

17 THE CHAIRMAN: Over 1,000?

18 I think there are about 1,000 in rotation.

19 THE CHAIRMAN: And what is the three-

20 year basis that you will graduate about 600 a year?

21 MISS SCHUMACHER: Yes, and, no, for the

22 three-year program, of course we do have ---

23 THE CHAIRMAN: And what is the University?

24 Hospital now leading to a degree in Bachelor of Science

25 in Nursing.

26 MISS SCHUMACHER: That is right.

27 THE CHAIRMAN: Graduating how many a year?

28 MISS SCHUMACHER: About 600 a year.

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1 THE CHAIRMAN: So that, looking at it from
2 the practical standpoint, you would have to increase the
3 size of the school by 180 times to bring all your nurses
4 along that road?

5 MISS SCHUMACHER: That is correct; that is
6 correct.

7 THE CHAIRMAN: And even if you open up a
8 new school, it is not contemplated that they are going to
9 have accommodation for 1800 pupils?

10 MISS SCHUMACHER: Oh, no.

11 THE CHAIRMAN: Or are they talking of a
12 forty or fifty pupils, that we have heard in other places?

13 MISS SCHUMACHER: Well, with a new school
14 that is being planned now, they are thinking more in terms
15 -- well, I cannot really say, because I have not been told,
16 but I would imagine it is comparable with present schools,
17 with hospitals of the same size, which would probably be
18 maybe 200.

19 THE CHAIRMAN: How many schools? That
20 would take nine schools?

21 MISS SCHUMACHER: To graduate 200 students
22 with a degree in nursing?

23 THE CHAIRMAN: Well, I do not know. I am
24 just putting the question.

25 MISS SCHUMACHER: I am sorry, Mr. Chairman.
26 I am not quite sure I know what you mean.

27 THE CHAIRMAN: Perhaps I am not being
28 quite clear about it, but the number of schools to graduate
29 200 a year -- let us put it this way. How many medical
30 students are being graduated from a Medical College in a



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27 THE CHAIRMAN: I am not sure I am not
28 quite clear about it, but the number of schools to graduate
29 200 a year -- let us put it this way. How many medical
30 students are being graduated from a Medical College in a



1 year? It is in the neighbourhood of fifty, is it not?

2 I may be wrong on that.

3 MR. MILLER: I think Dr. Bramley-Moore
4 may be able to tell you. The Registrar, Dr. Bramley-
5 Moore.

6 DR. BRAMLEY-MOORE: This year, sir, there
7 will be 61.

8 THE CHAIRMAN: We were led to believe
9 that that just about stretches the resources of the
10 Province of Alberta in the field of medical education?

11 I am just posing that; you say you have
12 financial obstacles to overcome to reduce the course from
13 three years to two years.

14 In the light of that, do you regard that
15 this idea of new governmental schools to take over from
16 the hospital schools as anything realizable in this
17 generation?

18 MISS SCHUMACHER: Oh, yes, I do, Mr.
19 Chairman. Our largest schools graduate approximately
20 one hundred graduates a year, so that this makes a
21 difference, too.

22 I think in looking at the educational
23 picture, if I may, if we look at the whole picture of
24 nursing taken in the Province, I think, then, this area
25 of it falls into place much more, and this is only one
26 section of it with the outline that I have on page 47.

27 One of the other situations that was brought
28 up in Miss Bietsch's presentation was the preparation of
29 the psychiatric nurse which, at the present time, is three
30 years, and the graduate does not qualify to be an R.N.



I may be wrong on that.

MR. MILLER: I think Dr. Bramley-Moore

may be able to tell you. The Registrar, Dr. Bramley-

Moore.

DR. BRAMLEY-MOORE: This year, sir, there

will be 51.

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section of it with the outline that I have on page 47

One of the other suggestions that was made

in Miss Blevins' presentation was the preparation of

the psychiatric nurse which, at the present time, is three

years, and the graduate does not qualify to be an R.N.



1 THE CHAIRMAN: And you propose that she
2 should be integrated into the course so that she would
3 be an R.N.?

4 MISS SCHUMACHER: That is correct. This,
5 then, would mean that there would be, again, an increase
6 in the number of R.N.'s. But besides that, it would give
7 an opportunity for this individual to go on for further
8 preparation to become a qualified head nurse or supervisor,
9 which at the present time these people have to do, because
10 they have to staff the mental hospitals.

11 But, unfortunately, they are not able to
12 go on because of their lack of preparation. This program
13 was started a number of years ago because of the need
14 in the mental hospitals and the entrance requirement was
15 set lower than the regular basic R.N. program. We have
16 now found that there is a definite trend; that the students
17 applying to the psychiatric nurse course, that the
18 academic preparation is almost the same as our own students,
19 and some of them do have the same academic preparation,
20 but they still cannot qualify into our Association because
21 their program has been centered around the psychiatric
22 nurse training and not a general education.

23 So, we feel -- our belief is that the
24 patient in the mental hospitals requires a nurse who has
25 general nursing preparation as well as psychiatric pre-
26 paration. We state that the graduate in general nursing
27 must have psychiatric preparation. We think the converse
28 is true, and this is why we are proposing the psychiatric
29 nurse program be studied, so that this can be brought into
30 line.



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is true, and this is why we are proposing the psychiatric

nurse program be studied, so that this can be brought into



1 If this is done, then, again, these people
2 will be able to join the stream of becoming leaders.

3 This is the same situation in our hospital,
4 the defective mental hospital.

5 THE CHAIRMAN: I do not want to appear to
6 be casting cold water on your very legitimate ambitions;
7 but if you are suggesting the setting up of a number of
8 schools, the next revisions that we, as a Commission,
9 are going to hear is that somebody should provide the
10 money, and that is where it becomes very much within the
11 compass of this investigation.

12 MISS SCHUMACHER: Yes, but what we are
13 proposing is not going to increase the cost that much, we
14 do not believe.

15 THE CHAIRMAN: What is "that much"?

16 MISS SCHUMACHER: Well, from the stand-
17 point that the program of the psychiatric nurse, and we
18 have not made any major changes of our present programs,
19 excepting from the standpoint of separate committees,
20 separate budgets, and improving educational policies.

21 This is the interim phase, so that we can
22 continue to provide nursing services as well as sound
23 nursing education to the public. We feel that, looking at
24 it on a long term range program, and this is, I think,
25 what we have to look at, as you indicated a few minutes
26 ago, we are becoming more diluted. We are having an
27 increase in auxiliary staff nurses; they are having to
28 assume more leadership roles. This is why we are pre-
29 senting the idea of the two-year program, and then going
30 on, we also feel that if there is a two-year program that



1 this will attract a better selection of students, and then
2 we can have more, from that standpoint. We feel that,
3 with a better selection --

4 THE CHAIRMAN: How many of the two-year
5 people would you contemplate graduating per year?

6 MISS SCHUMACHER: This is very difficult
7 to project, but I think it would increasingly be on the
8 increase as far as the enrolment is concerned.

9 THE CHAIRMAN: What would be the governing
10 factor in the increased intake? Of course, facilities?

11 MISS SCHUMACHER: Facilities and prepara-
12 tion of personnel which is another great need of adequate
13 preparation.

14 THE CHAIRMAN: Can you give me any figure?
15 Is it 25, 50, 100, or 200?

16 MISS SCHUMACHER: We have done our cost
17 study on the basis of 200 students and, of course, we
18 were being optimistic. I would think probably the first
19 class might start with 25 or 50 and then increase but
20 we have looked at it on the basis of 200.

21 COMMISSIONER McCUTCHEON: Two hundred a
22 year?

23 MISS SCHUMACHER: One hundred a year.

24 THE CHAIRMAN: And your cost comes to
25 what?

26 MISS SCHUMACHER: This is on page 45. This,
27 I would like to add, was worked on by a group who were
28 studying the two-year program. The figures have been
29 obtained from Schools of Nursing from which the group
30 came and, the figures they were able to get. Also they



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16 study on the basis of 200 students and, of course, we

17 were being optimistic. I would think probably the first

18 class might start with 25 or 50 and then increase but

19 we have looked at it on the basis of 200.

20 COMMISSIONER: Now, how many of the two-year

21 THE CHAIRMAN: And your best guess is

22 what?

23 MISS SCHUMACHER: This is on page 45. This

24 I would like to add, was worked on by a group who were

25 studying the two-year program. The figures have been

26 obtained from schools of nursing from which the group

27 came and, the figures they were able to get. Also they



1 contacted the Junior College in their City to see what the
2 cost of tuition fees was and so on. The operating costs
3 of the residence they figured would be \$133,000.00. The
4 operating costs of the school were set at \$110,700.00 and
5 this was to include thirteen to fourteen teachers; thinking
6 of it in terms of two hundred students at the ratio of
7 one to fifteen, this is a high ratio. The Nightingale
8 School in Toronto is using the ratio of one to ten so
9 this might have to be increased. A Director of the
10 School, a clinical co-ordinator, a resident director,
11 a librarian, two secretaries and a part-time nurse, physician,
12 secretary health service. They take into consideration
13 the school equipment and supplies, the school library,
14 public relations, recreation and graduation and maintenance
15 at a total cost of \$110,700.00.

16 THE CHAIRMAN: These teachers would be
17 initially qualified nurses with post-basic training and
18 you would hope to get them for \$4,000. a year?

19 MISS SCHUMACHER: This is what we have
20 put down here and it is low.

21 THE CHAIRMAN: Well, it is about the
22 salary of a primary school teacher for after about three
23 years.

24 MISS SCHUMACHER: We are aware of that.

25 THE CHAIRMAN: I merely suggest it is an
26 unrealistic figure and certainly one that nurses should
27 be shooting for much higher.

28 In any event, you have the cost of the
29 residence and an income figure of about \$70,000.00 a year.

30 MISS SCHUMACHER: Yes.



1 contacted the Union College in their City to see what the
2 cost of winter fees was and so on. The operating costs
3 of the residence they figured would be \$133,000.00. The
4 operating costs of the school were set at \$110,700.00 and
5 this was to include fifteen to twenty teachers, thinking
6 of it in terms of two hundred students at the ratio of
7 one to fifteen. This is a high ratio. The Nightingale
8 School in Toronto is using the ratio of one to ten as
9 this might have to be increased. A Director of the
10 School, a clinical co-ordinator, a resident director,
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25 unrealistic figure and certainly one that nurses should
26 be shooting for much higher.

27 In any event, you have the cost of the

28 residence and an income figure of about \$70,000.00 a year.



1 THE CHAIRMAN: This would require new
2 buildings or are there buildings in being that could be
3 used?

4 MISS SCHUMACHER: In one of the new hospitals
5 there is a new residence that is being built. Again,
6 it would depend on where this was going to be established.
7 Supposing a school that is already established, you may
8 affiliate and they would be willing to try it out and then
9 we would have the accommodation, also teachers.

10 THE CHAIRMAN: Thank you very much, this
11 is a very lucid explanation.

12 MISS BIETSCH: May I add one more thing.
13 Our whole study was prompted by the challenge given to
14 us by the Minister of Health in April of last year in
15 which he indicated he was increasing hospital beds by
16 1968 by 5,932, which would require an additional 1,340
17 registered nurses. Thinking in terms of the number of
18 students that have been graduating at the present time,
19 approximately 500, and we have been averaging 250 to 300
20 reciprocal registrations, we felt we must do something
21 to increase our student enrolment. The twelve schools
22 in existence now are carrying pretty well their maximum
23 load, therefore the talk of an independent school, utilizing
24 another hospital independent in that the student would not
25 be relied on for service. If our twelve schools were
26 converted to independent schools it would be a catastrophe
27 because these students are giving service in return for
28 their nursing education.

29 COMMISSIONER GIRARD: Miss Bietsch, in
30 view of the fact that you cited that the students came



THE CHAIRMAN: This would require new

buildings or are there buildings in being that could be

MRS. SCHUMACHER: In one of the new hospitals

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THE CHAIRMAN: Thank you very much. This

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MRS. SCHUMACHER: Yes, I add one more thing

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COMMISSIONER GIBSON: Miss Bishop, in

view of the fact that you cited that the students were



1 tenth or after tenth place in the National test pool
2 examinations of psychiatry, how long is that psychiatric
3 affiliation for students in the psychiatric hospital?

4 MISS BIETSCH: Eight weeks.

5 COMMISSIONER GIRARD: Do you feel that is
6 long enough?

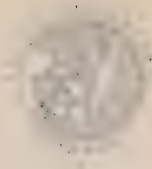
7 MISS BIETSCH: No, we would like to have a
8 twelve-week period which is the minimum period elsewhere.
9 However, residence accommodation does not permit this at
10 the provincial hospitals, so consequently it means exposing
11 a few students to the twelve weeks. However, if all of
12 our students get an appreciation of psychiatric nursing
13 in the eight-week period, then we hope if they go anywhere
14 where three months is the requirement they would have
15 added experience in a psychiatric hospital.

16 COMMISSIONER GIRARD: You would prefer three
17 months?

18 MISS BIETSCH: We certainly would.

19 COMMISSIONER GIRARD: Mrs. Larson, what
20 are the reasons why only half of the public health nurses
21 are qualified in public health nursing as stated on page
22 18?

23 MRS. LARSON: I think that probably to
24 begin with we have a lack; we are expanding our services
25 and we have a lack of qualified personnel. With your
26 registered nurses in most instances, I am thinking perhaps
27 that on occasion there will be a nurse employed who is
28 not registered as we call registration in Alberta. I
29 think probably it is lack of personnel, qualified person-
30 nel and the fact that these services are enlarging all the



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27 think probably it is lack of personnel, qualified person-
28 nel and the fact that these services are enlarging all the



1 time and perhaps the employers do not feel the necessity
2 of hiring the more qualified person.

3 COMMISSIONER GIRARD: When you say not hir-
4 ing the more qualified person, would he hire nurses or non-
5 nurses?

6 MRS. LARSON: I am thinking of your public
7 health nurse.

8 COMMISSIONER GIRARD: Do you have any
9 bursaries?

10 MRS. LARSON: Yes, there are bursaries.

11 COMMISSIONER GIRARD: It is not lack of
12 bursaries?

13 MRS. LARSON: No, I think it is perhaps a
14 lack of trying to encourage them to take post-graduate
15 study setting up certain goals for them to attain.

16 COMMISSIONER GIRARD: Is salary one of the
17 encouragements? Is there a difference in salary for the
18 qualified public health nurse?

19 MRS. LARSON: To a certain extent. I think
20 personnel policies become sort of local problems; there is
21 not an unanimity in salaries paid in our rural health
22 units and I could not be sure about salaries as paid in
23 some. I am aware of what is being paid in a number of
24 them, but I think salaries might be one of the incentives,
25 although in some instances I think they are being paid
26 fairly well even with not having public health post-graduates.

27 COMMISSIONER GIRARD: Thank you very much.

28 COMMISSIONER BALTZAN: Miss Schumacher,
29 I do not blame you a bit in connection with your advocacy
30 of independent schools that you base your claim on my



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1 teaching for the past 25 years of nurses. To be less
2 factitious and more to the point, I am going to ask you
3 a few simple questions. You state on page 14 in that
4 connection that: "The further establishment of hospital
5 schools". My question is, would that eliminate or dis-
6 qualify hospital schools, religious orders with two
7 hundred or three hundred years' experience in the training
8 of nurses?

9 MISS SCHUMACHER: Not necessarily from
10 the standpoint that there is no reason why the Catholic
11 School cannot become affiliated in this two-year program.

12 COMMISSIONER BALTZAN: Would you explain
13 how it would fit into the scheme? Perhaps that was done
14 and I did not hear it.

15 MISS SCHUMACHER: I think we need further
16 study on this. We are very much aware of the place of
17 the Catholic Schools, after all, we do have five in our
18 Province. However, we feel if the school would wish to
19 become affiliated then there would be sufficient represen-
20 tation on this separate board from the school that the
21 school would be able to continue with its philosophy,
22 and employ its own personnel meeting the qualifications
23 that have been set out. We cannot see that it will
24 eliminate the Catholic School philosophy or the Catholic
25 School per se; it would be in affiliation.

26 THE CHAIRMAN: One of the hospitals could
27 pick up the program if it so wished?

28 MISS SCHUMACHER: Yes.

29 COMMISSIONER BALTZAN: Are they not
30 affiliated with the University now? The schools in other



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THE CHAIRMAN: One of the hospitals could pick up the program if it so wished? MISS SCHUMACHER: Yes. affiliated with the University now? The schools in other



1 provinces, these schools have an affiliation with the
2 University?

3 MISS BIETSCH: They are approved by the
4 University.

5 COMMISSIONER BALTZAN: There is a
6 distinction?

7 MISS BIETSCH: Yes, there is.

8 SISTER LE CLERC: May I just point out here
9 what we have been thinking in the Sister Schools which I
10 would like to call the Catholic Schools. In my inter-
11 pretation here, we feel very much that we would like to
12 maintain the high standards of nursing education in view
13 of high standards of nursing care. However, if at one
14 time the independent, the program of the independent
15 Schools of Nursing proved to be the best way of giving
16 the best education for students, we would like then to
17 have Sister independent Schools of Nursing with the
18 same financial support that the other independent Schools
19 of Nursing would receive. We do not feel that only re-
20 presentation on the board for independent Schools of
21 Nursing would preserve our philosophy enough.

22 COMMISSIONER BALTZAN: I am pleased with
23 your answer because it helps my thinking. My next
24 question is, under these circumstances will students pay
25 for tuition?

26 SISTER LE CLERC: We do feel this would
27 curtail the recruitment of students in some areas.

28 COMMISSIONER BALTZAN: But this would be
29 required in order to maintain these schools on the same
30 basis as junior colleges or universities are expected to



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1 pay for tuition and board and room, they would have to
2 pay or be subsidized.

3 SISTER LE CLERC: That is right.

4 COMMISSIONER BALTZAN: Would the hospitals
5 that you mentioned here be called upon to provide, I think
6 you say clinical facilities, would they be compensated
7 in any way (a) for preparing classes, receiving these
8 nurses appearing for designated instruction and (b) would
9 they be compensated for the cost of labour in the disruption
10 of the hospital routine? After all, we have to think
11 in terms of added costs to the hospital. I know what
12 happens when medical students come to hospitals, everybody
13 gets into a flurry. In these hospitals where they re-
14 ceive this clinical instruction would they receive some
15 compensation?

16 MISS SCHUMACHER: This has not been
17 clarified as yet, but there would have to be some arrange-
18 ment or some understanding in order to meet this.

19 COMMISSIONER BALTZAN: I am mentioning
20 this not in the form of criticism, but in considering
21 your total project that in terms of cost this should also
22 be considered. Lastly, when it comes to building these
23 institutions, have you given thought to who will do that
24 besides the carpenters? Will it be the Department of
25 Health or will it be the Department of Education?

26 MISS SCHUMACHER: Up until the present
27 time it has been the Department of Health that has assumed
28 the cost of building. At the present time with the
29 number of facilities we have and the facilities that
30 are going to be, it is going to be difficult to say how



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29 are going to be, it is going to be difficult to say how



1 much more we would need.

2 COMMISSIONER BALTZAN: You see, you are
3 going now from the point of training to the point of
4 education. Up until now both training and education were
5 combined and you are making a bit of a division of the
6 classes as to will it be the Department of Health or the
7 Department of Education?

8 MISS SCHUMACHER: That is right.

9 COMMISSIONER BALTZAN: Lastly, will there
10 be more than one school, a university centered school?

11 MISS SCHUMACHER: Again, this independent
12 school, it would depend on where it fitted into the
13 situation. As we have mentioned in our Brief, this could
14 be with the University and if it is directly with the
15 University the costs would be borne through the University;
16 if it is with the Junior College, say, this is where it
17 would be at the present time. We have three Junior
18 Colleges in our Province, one in Calgary, one in Lethbridge,
19 and one in Camrose. Perhaps what we have to look at if
20 we get the green light to look into the situation, we would
21 need to look to see whether it would be in Calgary or
22 Lethbridge. We have suggested in our Brief that perhaps
23 Calgary is the spot for the simple reason that there is
24 no University School of Nursing per se down there. We
25 feel it may be the place to begin. Lethbridge might be
26 another school. I think this would also depend on the
27 population and the increase in population, so there are
28 other factors but we suggest Calgary is the preferable
29 site first.

30 COMMISSIONER BALTZAN: Thank you, you have



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COMMISSIONER BATTAN: Thank you, you have



1 clarified my thinking a good deal.

2 COMMISSIONER VAN WART: I realize this is
3 a Brief being presented by the Registered Nurses Association
4 of Alberta, but there is another group of nurses nursing
5 in our hospitals and as yet we have had no briefs from
6 them and not much information. Therefore, I am asking
7 these questions more to seek information or seek your
8 relationships with them, namely, the nursing assistants.
9 Do you consider nursing assistants useful in your hospitals?

10 MISS BIETSCH: Very much so.

11 COMMISSIONER VAN WART: Are they on the
12 increase in numbers in your hospitals?

13 MISS BIETSCH: Mr. Chairman, I think that in
14 some hospitals the number of certified nursing aides
15 employed have been on the increase especially as we follow
16 the team plan of nursing and again according to the amount
17 of money available to nursing services.

18 COMMISSIONER VAN WART: Just to clarify
19 the record for the Commission, we do distinguish between
20 the nursing assistants and the nursing aide?

21 MISS BIETSCH: Mr. Chairman, the Certified
22 Nursing Aide is our title for the nursing assistant or the
23 licensed practical nurse after a ten month
24 program under the Department of Public Health and the
25 Vocation Branch of the Department of Education, which I
26 believe, is the pattern of all provinces. Some of these
27 have a twelve month program.

28 COMMISSIONER VAN WART: In the hospital
29 are they directly under the nurses, the registered nurses'
30 program?



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27 and they directly under the nurses, the registered nurses,

28 program?



1 MISS BIETSCH: Yes, they are, sir.

2 They are under nursing services whereas the other personnel
3 come under union associations.

4 COMMISSIONER VAN WART: Are they a
5 group? Can they be promoted to R.N. by taking an examina-
6 tion and so on?

7 MISS BIETSCH: If any of them have the
8 academic qualifications which are needed for registration,
9 for preparation for professional nurse training, there is
10 nothing to prohibit them from going in this program. We
11 have had instances where a Certified Nursing Aide has
12 entered the School of Nursing.

13 COMMISSIONER VAN WART: If a nursing aide
14 shows competence and ability in assistance, she cannot
15 become an R.N. unless she has had the preliminary education
16 equivalent to the R.N. nurse?

17 MISS BIETSCH: That is right. The only
18 means we have of giving her a feeling of achievement is
19 the annual increment which usually reaches a limit after
20 three years or so. There is no promotion for this
21 person.

22 COMMISSIONER VAN WART: They are static
23 in other words, if they haven't had the preliminary
24 education.

25 MISS BIETSCH: That is right.

26 COMMISSIONER VAN WART: Are there grades
27 of duties for these or are the duties all similar for
28 a nursing aide?

29 MISS BIETSCH: Their duties, Mr. Chairman,
30 are very clearly defined by the Schools for Nursing Aides,



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1 and the girls, the nursing aides are allowed to practice
2 within the scope of these duties. Anything beyond these
3 duties they assume responsibility for, they are endangering
4 the loss of their license by the Department of Public
5 Health.

6 COMMISSIONER VAN WART: The School of
7 Nursing Aides is an instrument of the Department of Health.

8 MISS BIETSCH: The Department of Education
9 and the Vocational Branch.

10 COMMISSIONER VAN WART: Do they have a
11 separate board?

12 MISS BIETSCH: They have an Advisory
13 Committee on which we have representatives.

14 COMMISSIONER VAN WART: Controlled by
15 the Department of Health and Department of Education?

16 MISS BIETSCH: Yes sir.

17 COMMISSIONER VAN WART: Is that similar
18 in other provinces?

19 MISS BIETSCH: May I refer this to Mrs.
20 Sabin.

21 MRS. SABIN: I am not sure of that, sir.

22 COMMISSIONER VAN WART: Do these nurses
23 aides live in or live out of hospitals?

24 MISS BIETSCH: They start their program
25 at the school in Calgary or Edmonton and they live out
26 while they have their basic ten weeks, I believe, in that
27 school. Then they affiliate at the hospitals, some of
28 the Schools of Nursing have affiliate centres for the
29 Schools of Nursing Aides and are mental hospitals as well.
30 Then they are provided with their room and board and



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When they are provided with their room and board and



1 education at this time, but the stipend comes from the
2 Department of Public Health.

3 COMMISSIONER VAN WART: Is this a fair
4 assumption then, without the nursing aide in the hospital
5 it would be impossible for the registered nurses to put
6 in their projected program? They would have to do this
7 work themselves.

8 MISS BIETSCH: What do you mean projected
9 program, our new schools?

10 COMMISSIONER VAN WART: Your program of
11 training supervisors and operating nurses and so on.

12 MISS BIETSCH: The duties, sir, run
13 parallel. They do not coincide. The nursing aide can
14 never accept her responsibilities.

15 COMMISSIONER VAN WART: If you had no
16 nursing aides the registered nurses would have to do the
17 work.

18 MISS BIETSCH: That is right, so there
19 would be a lot fewer people receiving care. This is one
20 danger we face if we think in terms of immediately transferring
21 our schools to an independent program. We have all
22 these students who give nursing care. Who would replace
23 them. I think you are right, it would probably be the
24 nursing aide doing the work.

25 COMMISSIONER VAN WART: They have a very
26 important function in your system.

27 MISS BIETSCH: They certainly do.

28 COMMISSIONER VAN WART: I think the registered
29 nurse has an important responsibility to them.

30 MISS BIETSCH: That is right, sir.



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nursing side doing the work.

COMMISSIONER VAN WART: They have a very

important function in your system.

MISS BISHOP: They certainly do.

COMMISSIONER VAN WART: I believe the registered

nurses are an important responsibility to them.

MISS BISHOP: That is right, sir.



1 COMMISSIONER STRACHAN: Can the nursing
2 aides be male or female?

3 MISS BIETSCH: I don't know, sir, if there
4 is anything that prevents it. There are not any.

5 THE CHAIRMAN: Perhaps the wage scale.

6 MISS BIETSCH: The wage scale would. We
7 hoped the orderlies would be trained by the School for
8 Nurses Aides, but the wage scale would be different there.

9 COMMISSIONER VAN WART: The salary of the
10 nursing aide is very much less than the registered nurse?

11 MISS BIETSCH: At the present time the
12 salary is based on 70% of what the registered nurses re-
13 ceive. This 70%, if I may explain has no connection or
14 no implication of preparation whatsoever. It was started
15 on the basis of 70% of the nurse's salary to be a living
16 wage. At that point I think it was \$135.00 back in 1951.
17 It has been continued to be maintained. I think if we
18 look at it realistically, I am speaking for myself now,
19 if we look at it realistically 70% of what the R.N. earns,
20 let us \$300.00, \$210.00 as a wage that the nursing aide
21 merits. I very strongly endorse that.

22 COMMISSIONER STRACHAN: If the nursing
23 aides decides to train as a R.N. and has the necessary
24 qualifications, does she get any credit for her time spent?

25 MISS BIETSCH: I refer this to Miss
26 Schumacher.

27 MISS SCHUMACHER: Mr. Chairman, at the
28 present time she does not get any credit to my knowledge.
29 This question has also been brought up. We have suggested
30 if a nursing aide wishes to continue or to start this kind

2 sides be male or female?

3 MISS STEPHENSON: I don't know, sir, if there

4 is anything that prevents it. There are not any.

5 THE CHAIRMAN: Perhaps the wage scale.

6 MISS STEPHENSON: The wage scale would. We

7 hoped the orderlies would be trained by the 2nd of Jan.

8 Nurses aides, but the wage scale would be different there.

9 COMMISSIONER VAN WART: The salary of the

10 nursing aide is very much less than the registered nurses.

11 MISS STEPHENSON: At the present time the

12 salary is based on 70% of what the registered nurses re-

13 ceive. This 70%, if I may explain has no connection in

14 no implication of proportion whatsoever. It was started

15 on the basis of 70% of the nurse's salary to be a living

16 wage. At that point I think it was \$125.00 back in 1953.

17 It has been continued to be maintained. I think if we

18 look at it realistically, I am speaking for myself now,

19 if we look at it realistically 70% of what the R.N. earns

20 let us \$300.00, \$270.00 as a wage for the nursing aide

21 means a very strongly endorsed fact.

22 aides decide to train as a R.N. and has the necessary

23 qualifications, does she get any credit for her time spent

24 MISS STEPHENSON: I refer this to Miss

25 MISS SCHIMMACHER: Mr. Chairman, at the

26 present time she does not get any credit to my knowledge.

27 This question has also been brought up. We have suggested

28 if a nursing aide wishes to continue on to start this kind



1 of program to apply to the School of Nursing and the
2 University would look at what credit she could be given.
3 Until the present time the answer is no.

4 COMMISSIONER VAN WART: Coming to another
5 subject, there is one question I want to ask. I believe
6 the School of Training Midwives was started in Alberta.
7 Must these applicants be registered nurses?

8 MISS BIETSCH: Mr. Chairman, I will refer
9 this to Miss Schumacher. We have had the School for a
10 long time now.

11 MISS SCHUMACHER: Yes, Mr. Chairman, it
12 is for graduate nurses and R.N. nurses.

13 COMMISSIONER VAN WART: Nursing aides
14 could not qualify.

15 MISS SCHUMACHER: No, no. May I make one
16 statement on nursing aides. This is one point brought
17 out in our recommendations in that we would want to study
18 this, to see if the nursing aide could be given credits
19 towards the three-year program, would this program be
20 better as part of our over-all nursing program if they
21 all start together. We have done no study on it at the
22 present time. That is one of the things we are going
23 to do.

24 COMMISSIONER FIRESTONE: Miss Bietsch,
25 on page 2, paragraph 2E, you suggest that consideration
26 be given to revising income tax regulations respecting
27 married women so as to encourage more women to re-enter
28 the nursing practice. Is this recommendation related
29 to married women in the nursing profession or to all
30 married women?



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2 COMMISSIONER VAN WART: Coming to another

3 subject, there is one question I want to ask. I believe

4 the School of Nursing Eldridge was started in Alberta.

5 Must there applicants be registered nurses?

6 MISS BIRCH: Mr. Chairman, I will refer

7 this to Miss Schenck. We have had the School for a

8 MISS SCHENCK: Yes, Mr. Chairman, it

9 is for graduate nurses and R.N. nurses.

10 COMMISSIONER VAN WART: Nursing class

11 could not qualify

12 MISS SCHENCK: No, no. May I make one

13 present time. That is one of the things we are going

14 to give to nursing income tax regulations respecting

15 married women so as to encourage more women to re-enter

16 the nursing practice. Is this recommendation related

17 to married women in the nursing profession or to all

18 married women?



1 MISS BIETSCH: Mr. Chairman, this is a
2 rather idealistic recommendation and we hope it would
3 affect all married women. It would have to, naturally.
4 It is something that is keeping our married nurses from
5 returning. Their husbands won't let them earn more than
6 \$1,000.00. They come for a three month period. The
7 higher our salaries go the less time we have them.

8 COMMISSIONER FIRESTONE: Your recommendation
9 is with respect to all married women?

10 MISS BIETSCH: To all married women.

11 COMMISSIONER FIRESTONE: Based on the
12 necessity of getting more married women who are in the
13 nursing profession back into nursing.

14 MISS BIETSCH: That is right, sir.

15 COMMISSIONER FIRESTONE: If the Government
16 were to make an exception with respect to nurses only
17 because of the shortage of nurses would this be acceptable
18 to you, or would you still want to champion the cause
19 for all married women?

20 MISS BIETSCH: We would be content to
21 just champion it for nurses.

22 COMMISSIONER FIRESTONE: Have you any
23 specific point in mind or any specific change in mind?
24 Perhaps this question should be directed to Mr. Miller,
25 as to what type of change in regulations of income
26 taxes might be brought about.

27 MR. MILLER: The change would have to
28 be in the nature of an exemption, as one of the persons
29 who doesn't have to pay for the earnings that have been
30 made by virtue of professional earnings, just an exemption

MISS BIRNBOIM: Mr. Chairman, this is a

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is with respect to all married women?

MISS BIRNBOIM: To all married women.

COMMISSIONER WILKINSON: Based on the

necessity of getting more married women who are in the

nursing profession back into service.

MISS BIRNBOIM: That is right, sir.

COMMISSIONER WILKINSON: If the Government

is going to take an exception with respect to nurses only

because of the shortage of nurses would this be acceptable

to you, or would you still want to exempt the cause

for all married women?

MISS BIRNBOIM: We would be content to

have an exception for nurses.

COMMISSIONER WILKINSON: Have you any

specific point in mind on any specific change in kind?

Perhaps this question should be directed to Mr. Miller,

as to what type of change in relations of income

taxes might be proposed.

MR. MILLER: The change would have to

be in the nature of an exemption, as one of the persons

who doesn't have to pay for the earnings that have been

made by virtue of professional earnings, just an exemption



1 to the ordinary rule there.

2 COMMISSIONER FIRESTONE: Thank you very
3 much, Mr. Miller.

4 May I turn now, Miss Bietsch, to Paragraph
5 3B on page 2 where you say in respect to the use of
6 bursaries that further education be stimulated. How
7 adequate do you consider bursaries and how do you feel
8 these interest any people, any ladies taking up nursing and
9 using bursaries could be achieved?

10 MISS BIETSCH: If I may refer this to
11 Mrs. Sabin, first of all, to indicate the number of
12 nurses presently receiving bursaries in the Province, and
13 then to Miss Schumacher for stimulation of further ed-
14 ucation.

15 MRS. SABIN: Mr. Chairman, in the fiscal
16 year 1960 to 1961, there were forty-five graduate nurses
17 received bursaries for post-basic courses, and these
18 were given under Dominion - Provincial grants, and the
19 sum amounted to \$41,600.00.

20 COMMISSIONER FIRESTONE: What was the
21 average per nurse?

22 MRS. SABIN: I think it is about \$1,000.

23 COMMISSIONER FIRESTONE: \$1,000.00.

24 MRS. SABIN: And then for this year, I
25 understand there are about 34 nurses who have received
26 bursaries. I believe they amounted to about \$75.00 a
27 month for maintenance plus tuition, and in some instances
28 travelling as well.

29 COMMISSIONER FIRESTONE: Would you consider,
30 this question is addressed to Miss Schumacher, a bursary



1 to the ordinary role there.

2 COMMISSIONER FIRESTONE: Thank you very

3 May I turn now, Miss Blaisdell, to paragraph

4 3B on page 2 where you say in regard to the use of

5 courses that further education be stimulated. How

6 adequate do you consider courses and how do you feel

7 these interest any people, anybody taking up nursing and

8 using courses could be achieved?

9 MISS BLAISDELL: If I may refer this to

10 Mrs. Sablin, first of all, to indicate the number of

11 nurses presently receiving courses in the Province, and

12 then to Miss Schumacher for stimulation of further ed-

13 year 1960 to 1961, there were forty-five graduate nurses

14 received training for post-basic courses, and these

15 were given under Dominion - Provincial grants, and the

16 sum amounted to \$41,000.00.

17 average per course?

18 MRS. SABLIN: I think it is about \$1,000.

19 MRS. SABLIN: And then for this year, I

20 understand there are about 24 nurses who have received

21 training. I believe they amounted to about \$5,000 a

22 month for maintenance plus tuition, and in some instances

23 traveling as well.

24 COMMISSIONER FIRESTONE: Would you consider,

25 this question is addressed to Miss Schumacher, a battery



1 of approximately \$1,000.00 a year adequate enough to
2 attract a number of young ladies into taking this extra
3 training.

4 MISS SCHUMACHER: Mr. Chairman, I don't
5 know.

6 COMMISSIONER FIRESTONE: What would you
7 consider an adequate bursary?

8 MISS SCHUMACHER: I would like to think
9 about it before coming up with a definite statement, but
10 there is a great need in preparing leaders in our Province with
11 Post Baccalaureate Degree and secondly, this goes with
12 the second part of this statement, in order to stimulate
13 their interest I think you would have to have some recog-
14 nition financially. As we were saying the \$4,000. for
15 a teacher, then for someone who has prepared with a
16 Master's or further then it is most inadequate. I
17 would like to give this more thought.

18 COMMISSIONER FIRESTONE: What does it cost
19 to get that training? Bursaries should be adequate
20 enough to at least cover the cost. We don't expect the
21 ladies to have a holiday, but we expect them to be able
22 to cover their expenses. But what would you consider
23 would be necessary to cover training, living expenses,
24 tuition et cetera? Have you got an approximate figure,
25 the basis on which one could assess it?

26 MISS SCHUMACHER: I have here an
27 approximate figure for the cost of our University program
28 for the two years that the student spends at University.
29 Each year it costs \$290. which means \$580. I worked
30 room and board at approximately \$65. for a two-year period



2 attach a number of young ladies into taking this exam

3 training.

4 MISS SCHUMACHER: Mr. Chairman, I don't

5 COMMISSIONER FLEMING: What would you

6 consider an adequate barrier?

7 MISS SCHUMACHER: I would like to think

8 about it before coming up with a definite statement, but

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21 to cover their expenses. But what would you consider

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23 MISS SCHUMACHER: I have here an

24 for the two years that the student spends at University.

25 Each year it costs \$290, which means \$580. I worked



1 of eight months, \$1,040. Totalling that will be
2 \$1620. That is minimum. It doesn't take into con-
3 sideration any of their extras.

4 THE CHAIRMAN: That is an under-graduate?

5 MISS SCHUMACHER: It is an under-graduate.
6 It doesn't take into consideration travelling, going to
7 another country. There are only two Universities in
8 Canada offering a Master's, so I don't see how any one
9 could do it for less than \$2500.00, \$3,000.00 at the
10 minimum, plus the fact they are not earning.

11 COMMISSIONER FIRESTONE: Your recommendation
12 subject to further consideration would be an average
13 between \$2500.00 to \$3,000.00?

14 MISS SCHUMACHER: As a minimum.

15 COMMISSIONER FIRESTONE: As a minimum.
16 If you have second thoughts would you please communicate
17 them to us after consulting the other ladies on your
18 executive. If we don't hear from you, we will take it,
19 it is still your considered opinion that \$2500. to \$3,000.
20 is the minimum for bursaries to be adequate to cover
21 actual out-of-pocket expenses.

22 What could be done to stimulate increase
23 in use. One would be increased amount? Are there
24 some other things that could be done to increase or
25 stimulate the increased use of these bursaries beside
26 raising the amount? What else could be done?

27 MISS SCHUMACHER: I think if we had
28 different kinds of programs which would stimulate and
29 give the opportunity for these women to come back and
30 try out some of their new ideas that this would be a means



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2 \$1620. That is minimum. It doesn't take into con-
3 sideration any of their extras.
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10 minimum, plus the fact they are not earning.
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25 stimulate the increased use of these nurseries partly
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29 give the opportunity for these women to come back and
30 try out some of their new ideas that this would be a woman



1 of stimulation

2 SISTER LeCLERC: I don't think the
3 recognition of the preparation is adequate when they return.

4 COMMISSIONER FIRESTONE: What kind of
5 recommendation would you have in mind? This is a good
6 point.

7 SISTER LeCLERC: I am thinking, first of
8 all, salary, that is far from being adequate. We have
9 thought the 'simple registered nurses' salary is not
10 adequate and after they have gone, even on a bursary,
11 but not earning as Miss Schumacher has stated during that
12 period of time, when she returns it is a ridiculous
13 difference in salary that she is going to receive for
14 the time she has spent and the money she has also put
15 into this.

16 MISS BIETSCH: May I add one other facet.
17 May I say, I hope Sister LeClerc is ready to defend her-
18 self for saying the "simple registered nurse".

19 The big problem as I see it are students
20 don't have the academic requirements for University en-
21 trance when they enter the School of Nursing. We have
22 four High School diplomas. When a R.N. completes the
23 three-year program, she is going to think before she
24 takes math. third year or chemistry or some other that is
25 deficit in her matriculation. If all are students in
26 Alberta, and again we are being idealistic, could be
27 enrolled in the senior matriculation program, and at
28 least start on the math and science courses to direct
29 them to something else. At the tender age of 14 they
30 have to make a decision as to what they are going to be.



SISTER LECTURE: I don't think the

recognition of the preparation is adequate when they return

COMMISSIONER BARTON: What kind of

recommendation would you have in mind? This is a good

point.

SISTER LECTURE: I am thinking, first of

all, salary, that is far from being adequate. We have

thought the single regular salary is not

adequate and often they have gone, even on a salary,

but not earning as Miss Sommers has stated during that

period of time, when she returns is is a ridiculous

difference in salary that she is going to receive for

the time she has spent and the money she has spent

MISS HINDS: May I add one other point.

May I say, I hope Sister Lee and I need to defend her.

self for saying the "single regular salary"

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don't have the academic requirements for University en-

trance when they enter the School of Nursing. We have

four High School diplomas. When a N.N. completed the

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takes math, third year or university or some other that is

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enrolled in the senior matriculation program, and as

least start on the math and science courses to direct

them to something else. At the moment one of 14 they

have to make a decision as to what they are going to do.



1 We have a great number of registered nurses who couldn't
2 go to University without a great amount of High School
3 preparation.

4 THE CHAIRMAN: Have you given thought
5 in Alberta to the program that is called the C.T.P.
6 program which exists in Saskatchewan, the Centralized
7 Training Program, four months of basic science at the
8 Regina College?

9 MISS BIETSCH: Mr. Chairman, for a period
10 of years we have studied various centralized programs
11 and various suggestions have been made and rejected. We
12 have changed our plan. Unless you have an adequate follow-
13 up in the Schools of Nursing to continue the studies that
14 were started in the centralized program, you are lost.
15 We don't have the people in our Schools of Nursing to
16 follow this up. The idea is if they had science at the
17 Central School you don't need a science instructor. You
18 do. You need a science instructor in the school to inte-
19 grate what has been learned. We haven't given it any
20 thought in the last two or three years, but the independent
21 program we are stressing is a little sister to the
22 Central program. We feel this will make it possible in
23 the schools to have the people who can integrate intelli-
24 gently what the student has learned in her independent
25 program.

26 COMMISSIONER BALTZAN: Miss Bietsch, one
27 question. You mentioned about the difficulties in re-
28 lation to the inadequacy of your matriculation program
29 here. Do these people who have entered the hospitals,
30 and received training and attained R.N.'s, my question is,



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2 go to University without a great amount of High School
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19 thought in the last two or three years, but the independent

20 program we are suggesting is a little closer to the

21 Central program. We feel this will make it possible to

22 the schools to have the people who can integrate intellig-

23 ently what the student has learned in her independent

24 COMMISSIONER BIRCH: Miss Birch, one

25 question. You mentioned about the difficulties in re-

26 lation to the independency of your matriculation program

27 here. Do these people who have entered the hospitals

28 and received training and obtained R.N.'s, my question is,



1 do they make good bedside nurses?

2 MISS BIETSCH: Yes, Mr. Chairman, a High
3 School diploma student who we are taking at the present
4 time who maybe deficit a couple of courses, science
5 courses at the grade twelve level is just as good a
6 clinical practitioner as a girl with her senior matricu-
7 lation. She is also a good head nurse. We have very
8 few head nurses and supervisors who have University pre-
9 paration. Even if she is interested and has financial
10 assistance to go on, she can't.

11 THE CHAIRMAN: That is what we are talking
12 about now.

13 COMMISSIONER FIRESTONE: On paragraph 5
14 on page 4 under sub-section C: "Public health nurses
15 in hospitals in out-patient departments to assist in
16 prevention of the return to hospital through health teaching
17 of the patient and his family and to plan for home care."
18 Would, in your opinion, if such a program were developed,
19 would it be possible as a result of such a program to
20 achieve a substantial saving in reduced hospital utilization?

21 MISS BIETSCH: Mr. Chairman, I will refer
22 this to Mrs. Larson.

23 MRS. LARSON: Mr. Chairman, we believe
24 that it would shorten the hospital stay and take the
25 patient home earlier. We are thinking now in terms of
26 and you heard the Victorian Order's Brief on Tuesday.

1 27 That type of home-care program, referral
28 systems, and your health teaching; that could be done
29 by nurses attached to out-patient departments. Public
30 health nurses, yes. We definitely feel that.



2 MISS BRYANT: Yes, Mr. Chairman, a High
3 School diploma student who we are talking at the present
4 time who maybe doesn't a couple of courses, science
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8 few head nurses and supervisors who have University pro-
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10 assistance to go on, she can't.
11 THE CHAIRMAN: That is what we are talking
12 about now.
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14 on page 4 under sub-section C, "Public Health Nurses
15 in hospitals in one-patient departments to assist in
16 prevention of the return to hospital through health teaching
17 of the patient and his family and to plan for home care."
18 Would, in your opinion, if such a program were developed,
19 would it be possible as a result of such a program to
20 achieve a substantial saving in reduced hospital utilization?
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22 Yes, Mr. Chairman.
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24 that it would shorten the hospital stay and take the
25 patient home earlier. We are thinking now in terms of
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27 That type of home-care program, relative
28 systems, and your health teaching, that could be done
29 by nurses attached to one-patient departments, public
30 health nurses, yes. We definitely feel that.



1 COMMISSIONER FIRESTONE: And the cost
2 that would be involved in paying the salaries of the
3 nurses providing service would be substantially less than
4 it would cost us to keep the patient in the hospital beds.
5 Is that your judgment?

6 MRS. LARSON: Yes.

7 COMMISSIONER FIRESTONE: To come to the
8 last question, paragraph 57 on page 29. You say there,
9 with reference to auxiliary personnel:

10 "There are no programs available for these groups
11 except in a limited way as an in-service program
12 of the specific institution."

13 Would you have in mind that in order to
14 improve the training facilities for auxiliary nursing
15 personnel, they ought to be trained in vocational schools
16 on a basis of an organized educational plan?

17 MISS BIETSCH: That is what we have in
18 mind, sir, and that is what we have in the recommendation,
19 that this be under the vocational school. It would save
20 a tremendous number of hours in a ward situations.

21 COMMISSIONER FIRESTONE: It would, and in
22 addition to that, you would have better trained auxiliary
23 personnel?

24 MISS BIETSCH: Yes, and uniformity.

25 THE CHAIRMAN: Thank you very much, Miss
26 Bietsch and Mr. Miller, and the other ladies who have
27 come in this delegation this morning. This discussion
28 has been most helpful, and it is obvious from the reading
29 of your Brief that a great deal of time and consideration
30 has gone into the preparation of the Brief and the ideas



2 that would be involved in paying the salaries of the
3 nurses providing service would be substantially less than
4 it would cost us to keep the patient in the hospital beds.
5 Is that your judgment?
6 MRS. LARSON: Yes.
7 COMMISSIONER FIRSTONE: We come to the
8 last question, paragraph 27 on page 29. You say there
9 with reference to auxiliary personnel:
10 "There are no programs available for these groups
11 except in a limited way as an in-service program
12 of the specific institution."
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14 improve the training facilities for auxiliary nursing
15 personnel, they ought to be trained in vocational schools
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18 mind, sir, and that is what we have in the recommendation,
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20 a tremendous number of hours in a ward situation.
21 COMMISSIONER FIRSTONE: It would, and in
22 addition to that, you would have better trained auxiliary
23 personnel?
24 MISS BIRNCH: Yes, and uniformly.
25 THE CHAIRMAN: Thank you very much, Miss
26 Birnch and Mr. Miller, and the other ladies who have
27 come in this delegation this morning. This discussion
28 has been most helpful, and it is obvious from the reading
29 of your Brief that a great deal of time and consideration
30 has gone into the preparation of the Brief and the ideas



1 which are contained in it, and your submission will receive
2 our very careful attention.

3 As you know, in addition to what is being
4 a public inquiry by the Commission of this nature, we
5 have our study projects underway and nursing education
6 is receiving very special consideration in these projects.

7 Thank you very much.

8 MISS BIETSCH: Mr. Chairman, on behalf
9 of the Committee and the members of the A.A.R.N., who I
10 see are really supporting us this morning, I would like
11 to thank you for your very sympathetic hearing of all our
12 problems. Thank you very much.

13 THE CHAIRMAN: We will now take a short
14 recess.

15
16 ---RECESS

17
18 THE CHAIRMAN: The next item on our
19 agenda was to have been a submission from the Catholic
20 Family and Child Service. We had asked them to come
21 forward so that we might question them as having to do
22 with the consumers of health services.

23 THE SECRETARY: I have received advice
24 that Reverend Father Irwin is away from the City on duty
25 and could not be here for this presentation this morning.
26 He has left the submission with me, and it will be filed
27 as Exhibit 129 and will be circulated to the Commission.

28
29 ---EXHIBIT 129: Submission of the Catholic
30 Family and Child Service of
Edmonton.



Bliss

1 which are contained in it, and your submission will receive

2 our very careful attention

3 As you know, in addition to what is being

4 a public inquiry by the Commission of this nature, we

5 have our study projects underway and during education

6 Thank you very much

7 MISS BENTON: Mr. Chairman, on behalf

8 of the Committee and the members of the A.A.A.M., who I

9 see are really supporting us this morning, I would like

10 to thank you for your very sympathetic hearing of all our

11 problems. Thank you very much

12 THE CHAIRMAN: We will now take a short

13 recess.

14 --RECESS--

15 THE CHAIRMAN: The next item on our

16 agenda was to have been a submission from the Catholic

17 Family and Child Service. We had asked them to come

18 forward so that we might discuss them as having to do

19 with the concerns of health services.

20 THE SECRETARY: I have received advice

21 that Reverend Father Treen is away from the City on duty

22 and could not be here for this presentation this morning.

23 He has left the submission with me, and it will be filed

24 as Exhibit 129 and will be circulated to the Commission.



1 THE CHAIRMAN: And that deals in answer
2 to the information that we have asked for?

3 THE SECRETARY: That is correct, sir.

4 THE CHAIRMAN: Thank you very much.

5 We will now proceed to the Alberta Psychiatric
6 Nurses' Association.

7
8 ---EXHIBIT No. 130: Submission of the Alberta
9 Psychiatric Nurses' Association

10
11 SUBMISSION

12 of

13 ALBERTA PSYCHIATRIC NURSES' ASSOCIATION

14
15 APPEARANCES:

16 Mr. Quentin Fate

17
18 ---EXHIBIT No. 130A: Copy of Proposed Minimum
19 Curriculum.

20
21 ---EXHIBIT No. 130B: Copy of the Alberta
22 Psychiatric Nurses' Association Code of
23 Ethics.

24 THE CHAIRMAN: Mr. Fate.

25 MR. FATE: Mr. Chairman, and Members of
26 the Commission, I am afraid there is a bit of a misunder-
27 standing about this so that I am alone here this morning,
28 but this is a very brief Brief and it should not take too
29 long.



THE CHAIRMAN: And just deal in answer

to the information that we have asked for?

THE SECRETARY: That is correct, sir.

THE CHAIRMAN: Thank you very much.

We will now proceed to the Alberta Psychiatric

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--EXHIBIT No. 130: Submission of the Alberta

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ALBERTA PSYCHIATRIC NURSES' ASSOCIATION

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--EXHIBIT No. 130A: Copy of Proposed Minimum
Qualifications.

--EXHIBIT No. 130B: Copy of the Alberta

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THE CHAIRMAN: Mr. Watt.

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the Commission, I am afraid there is a bit of a misunder-

standing about this so that I am alone here this morning.

but this is a very brief Brief and it should not take too



BRIEF to the ROYAL COMMISSION on HEALTH SERVICES,
PREPARED in ACCORDANCE with ORDER-in-COUNCIL
P.C.1961 -883

1. Because the Alberta Psychiatric Nurses' Association is a relatively young and small organization, and since the nursing care of psychiatric patients is one of the major health problems in Canada, as well as in all other countries, it seems essential that the Royal Commission on Health Services should be made aware of the existence of this organization and its aims and objectives. The Alberta Psychiatric Nurses' Association is vitally interested in, and concerned with all phases of Mental Illness and the facilities for the prevention of this, and for the care and rehabilitation of persons suffering from it; however, since the Provincial Department of Public Health and many other organizations will more than adequately deal with these aspects, it is the purpose of this brief to deal with psychiatric nursing only.

Now, I would like to point out that this is merely one Branch of the Canadian Psychiatric Nurses' Association. This is merely the Alberta Association, the A.P.N.A.

2. INFORMATION REGARDING the OBJECTIVES and
MEMBERSHIP OF THE APNA

The APNA was formed in 1951 under the Alberta Societies' Act. In 1955 the Alberta Provincial Government passed the "Psychiatric Nurses' Training Act". At the present time there is a paid-up membership of 121 (men and women), with at least that many more eligible for membership in the Province. The APNA is a member of the Canadian Council of Psychiatric Nurses, which is comprised



REPORT to the ROYAL COMMISSION on HEALTH SERVICES
 P. 10, 1961

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 and since the nursing care of psychiatric patients is one
 of the major health problems in Canada, as well as in all
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 illness and the facilities for the prevention of such,
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 from it; however, since the Provincial Department of Public
 Health and many other organizations will more than adequately
 deal with these aspects, it is the purpose of this letter
 to deal with psychiatric nursing only.
 Now, I would like to point out that this
 is merely one branch of the Canadian Psychiatric Nurses'
 Association. This is merely the Alberta Association.

2. INFORMATION REGARDING THE ORGANIZATION AND
 MEMBERSHIP OF THE ANA

The ANA was formed in 1957 under the
 Alberta Societies' Act. In 1958 the Alberta Psychiatric
 Government passed the "Psychiatric Nurses' Training Act".
 At the present time there is a paid-up membership of 121
 (men and women), with at least that many more eligible for
 membership in the province. The ANA is a member of the
 Canadian Council of Psychiatric Nurses, which is comprised



1 of the Psychiatric Nurses' Associations of the Four
2 Western Provinces - Manitoba, Saskatchewan, Alberta and
3 British Columbia, with approximate membership of 2,600
4 in the Western Provinces.

5 The aims and objectives of the APNA are:

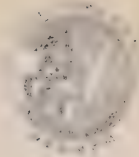
- 6 (a) To promote, improve and maintain an enlightened
7 and progressive standard of psychiatric nursing,
8 and to develop an active public interest in the
9 treatment and care of the mentally ill.
- 10 (b) To work in cooperation with any other approved
11 groups in the promotion of mental health and the
12 prevention of mental illness.
- 13 (c) To further the training and opportunity for
14 specialization for psychiatric nursing personnel.
- 15 (d) To encourage uniform training programs, of the
16 highest possible standard, for the purpose of
17 providing psychiatric hospitals, schools for the
18 mentally retarded, and public demand, with well
19 qualified psychiatric nurses.

20 3. Membership is limited to graduates in
21 psychiatric nursing. Students-in-training are eligible
22 for associate membership which promotes healthy student
23 interest.

24 4. MINIMUM ACADEMIC REQUIREMENTS

- 25 (a) 65 Alberta High School Credits.
- 26 (b) B standing or higher in literature, language,
27 social studies at grade XI level, and
28 Mathematics 20.

29 5. BASIC CURRICULUM: (Taught at the Nurses'
30 Training Schools at the Provincial Mental Hospital,



of the Psychiatric Nurses' Associations of the four

Western Provinces - Manitoba, Saskatchewan, Alberta and

The aims and objectives of the APNA are:

- (a) To promote, improve and maintain an enlightened and progressive standard of psychiatric nursing, and to develop an active public interest in the treatment and care of the mentally ill.

- (b) To work in cooperation with any other approved groups in the promotion of mental health and the prevention of mental illness.

- (c) To further the training and opportunity for specialization for psychiatric nursing personnel.

- (d) To encourage uniform training programs, of the highest possible standard, for the purpose of providing psychiatric hospitals, schools for the mentally retarded, and public demand, with well

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BASIC CURRICULUM: (Taught at the Nurses'

Training Schools at the Provincial Mental Hospital.



1 Ponoka, and the Institute at Oliver, and the
2 Provincial Mental Institute, Edmonton.)

3 THE CHAIRMAN: Mr. Fate, just at this
4 point, can you translate that into terms of full grade
5 XI or partial grade XII?

6 MR. FATE: It is full grade XI. That is
7 the maximum credits, I believe, that is obtainable in
8 grade XI in Alberta at the present time.

9 Preliminary Course - Psychiatric Nursing15 hours
10 Elementary Nursing Arts15 hours
11 First Year - Psychology.....30 hours
12 Psychiatric Nursing30 hours
13 Anatomy and Physiology.....50 hours
14 Microbiology.....10 hours
15 Pharmacology I.....20 hours
16 Pharmacology II.....30 hours
17 Nursing Arts.....105 hours
18 Pathology.....10 hours
19 Medical Nursing.....20 hours
20 Nutrition.....12 hours
21 347 hours

22 THE CHAIRMAN: That is over what period?
23 The number of months?

24 MR. FATE: Our present course starts in
25 August and is complete at the end of May.

26 THE CHAIRMAN: Eight months?

27 MR. FATE: Yes. That is class-room in-
28 struction.

29 THE CHAIRMAN: Pardon me --- nine months?

30 MR. FATE: Yes, nine months class-room



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struction.

THE CHAIRMAN: Pardon me -- nine months?

MR. FATE: Yes, nine months class-room



1 instruction; that is right.

2 Second Year - Medical Nursing20 hours

3 Surgical Nursing.....28 hours

4 First Aid.....18 hours

5 Psychiatry.....30 hours

6 Psychiatric Nursing.....30 hours

7 Sociology.....10 hours

8 136 hours

9

10 Third Year - Sociology15 hours

11 Psychiatry.....45 hours

12 Nursing Psychotherapy.....35 hours

13 Psychology.....26 hours

14 Ward Administration.....20 hours

15 Neurology and Communicable

16 Disease.....20 hours

17 Professional Adjustments.....5 hours

18 166 hours

19 GRAND TOTAL..649 hours

20 Field Trips4 days

21 Plus daily clinics and case studies throughout the
22 three years.

23 THE CHAIRMAN: Now, Mr. Fate, at this point
24 we may just pick up the thread as we go along. In the
25 second year, with 136 hours. That is still over the nine
26 month period?

27 MR. FATE: Yes, that is divided out.

28 Now, these are not always consecutive nine
29 month periods. We have been working on many systems of
30



1 instruction; that is right.

2 Second Year

3 First Aid.....18 hours

4 Sociology.....10 hours

5 136 hours

6 Third Year

7 Psychiatry.....15 hours

8 Psychology.....15 hours

9 Ward Administration.....15 hours

10 Neurology and Communicable

11 Disease.....15 hours

12 120 hours

13 GRAND TOTAL 640 hours

14 Field Work4 days

15 Five daily clinics and case studies throughout the

16 three years.

17 THE CHAIRMAN: Now, Mr. Tate, at this point

18 we may just pick up the thread as we go along. In the

19 second year, with 136 hours. That is still over one nice

20 month period?

21 MR. TATE: Yes, that is divided out.

22 Now, these are not always consecutive nine

23 month periods. We have been working on many systems of

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1 teaching --- the block system, where they are taught ex-
2 tensively in the class-room for two months, or for six
3 weeks, varying with the subject or subjects they are taking,
4 and then they are on the wards.

5 THE CHAIRMAN: These students are living
6 within the institution?

7 MR. FATE: Yes, the majority of them do.
8 There are, occasionally, some of the men who do not live
9 in, but the majority of them do.

10 THE CHAIRMAN: And the rest of the time
11 is put in clinical work?

12 MR. FATE: Yes, or any service work, plus
13 they do a great many clinics and case studies and that
14 sort of thing, which is done on their own time.

15 6. Essentially all members of the Alberta
16 Psychiatric Nurses' Association are employees of the various
17 Provincial Mental Hospitals and Institutions in this
18 Province.

19 7. It must be pointed out that there are general
20 nurses in Alberta who have also taken training in Psychiatric
21 Nursing - in fact, this Province has two such categories.
22 The Provincial Mental Hospital at Ponoka gives a four-year
23 course in general and psychiatric nursing (two years of
24 which are spent in affiliation at a general hospital),
25 which qualifies successful students to write the registered
26 nurses' examinations. There is also a "post-basic" course
27 in psychiatric nursing, of six months' duration, which is
28 for registered nurses, and which is also taught at the
29 Ponoka Hospital. This brief is not concerned with either
30 of the two latter categories, but only with graduates of



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16 Psychiatric Nurses' Association are employees of the various
17 Provincial Mental Hospitals and institutions in this
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19 It must be pointed out that there are general
20 nurses in Alberta who have also taken training in psychiatric
21 nursing - in fact, this Province has two such categories.
22 The Provincial Mental Hospital at Bonaville gives a four-year
23 course in general and psychiatric nursing (two years of
24 which are spent in affiliation at a general hospital),
25 which qualifies successful students to write the registered
26 nurses' examinations. There is also a "post-basic" course
27 in psychiatric nursing, of six months' duration, which is
28 for registered nurses, and which is also taught at the
29 Bonaville Hospital. This school is not concerned with either
30 of the two latter categories, but only with graduates of



1 the three-year course in psychiatric nursing which is
2 available for men and women, the curriculum of which has
3 already been outlined.

4 8. The APNA does not consider itself in a
5 position to make "recommendations" as such, but it would
6 respectfully point out the following problems which pre-
7 vent its members and others with similar qualifications,
8 from contributing to the utmost of their training, skill
9 and experience, to the care of the mentally ill. It is
10 sincerely believed that if all, or some of the following
11 suggestions could be carried out, it would go far toward
12 improving the treatment and care of psychiatric patients
13 in this Province, and would stimulate the flow of suitable
14 candidates (men and women) to the profession of psychiatric
15 nursing.

16 9. (a) Training and Standards - In order that the
17 present standard of training for psychiatric
18 nurses in Alberta be maintained and improved,
19 and that those psychiatric nurses trained
20 outside of the Province of Alberta meet this
21 standard, it is recommended that the training
22 program for psychiatric nurses be uniform
23 throughout the Province, and that a Provincial
24 examination be set up by an examining body
25 under the jurisdiction and direction of the
26 University of Alberta; this to be a pre-
27 requisite for the practising of psychiatric
28 nursing in the Province.

29 THE CHAIRMAN: Well, outside of institutions;
30 that is what you mean there?



the three-year course in psychiatric nursing which is available for men and women, the curriculum of which has already been outlined.

8. The AFNA does not consider itself in a position to make "recommendations" as such, but it would respectfully point out the following problems which prevent its members and others with similar qualifications, from contributing to the utmost of their training, skill and experience, to the care of the mentally ill. It is sincerely believed that it will, on some of the following suggestions could be carried out, it would go far toward improving the treatment and care of psychiatric patients in this Province, and would stimulate the flow of suitable candidates (men and women) to the profession of psychiatric nursing.

- (a) Training and Standards - It is recommended that the present standard of training for psychiatric nurses in Alberta be maintained and improved, and that those psychiatric nurses trained outside of the Province of Alberta meet this standard. It is recommended that the training program for psychiatric nurses be uniform throughout the Province and that a Provincial examination be set up by an examining body under the jurisdiction and direction of the University of Alberta; this to be a pre-requisite for the granting of psychiatric nursing in the Province.



1 MR. FATE: That is right; that is right.

2 (b) Advanced Training - Mental Hospital administrators,
3 the Provincial Government, and the Federal Govern-
4 ment, should recognize the need for post-graduate
5 training and experience for psychiatric nurses,
6 and should encourage and facilitate this in every
7 way possible, including adequate governmental
8 bursaries. Financial assistance should also be
9 made available for attendance of selected
10 psychiatric nurses from time to time, at appropriate
11 mental health institutes, work-shops, seminars,
12 et cetera.

13 (c) Recognition - If dedicated psychiatric nurses
14 are to be attracted to, and kept in the service of
15 psychiatric patients, they must be given recognition.
16 Whereas general nurses have long enjoyed the re-
17 cognition and respect of the public, physicians,
18 and all those who are concerned with the care and
19 treatment of physically ill patients, psychiatric
20 nurses as a group, have not as yet gained this
21 all-important recognition. Because of this,
22 many well-trained and experienced psychiatric
23 nurses are lost to the profession, sometimes be-
24 cause they are not adequately paid, or again,
25 because they are not placed in positions in keeping
26 with their training within the mental hospitals.
27 A professional psychiatric nursing staff must be
28 considered as being as essential to a progressive
29 mental hospital, as highly skilled and proficient
30 general nurses are to general hospitals.



Wanted

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branches. This need is especially acute in the

made available for the purpose of the

psychiatric nurses from time to time, at appropriate

mental health facilities, where appropriate

(c) Responsibility - It is the responsibility of the nursing profession

are to be introduced to the public in the form of an

psychiatric nurse, they must be given recognition

whereas the public has not been given the same

recognition as a result of the public's ignorance

and all efforts are directed with the aim of

treatment of psychiatric patients by the public

outlets as a result of the public's ignorance

many well-trained and experienced psychiatric

nurses are lost to the profession. Therefore the

cause there are not adequate funds, on a large

because they are not placed in positions in keeping

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A professional psychiatric nursing staff must be

considered as being as essential to a progressive

mental hospital, as highly skilled and professional

general nurses and to general hospitals.



1 Some psychiatric nurses are qualified to
2 take the general course of training which leads to
3 the "R.N.". This is not the answer, however,
4 since they are not interested in general nursing
5 as such, and some of the subjects necessary for
6 general nursing are entirely redundant in
7 psychiatric nursing - (e.g. obstetrics), and if
8 this were a "condition" of their training, many
9 excellent potential psychiatric nurses would be
10 lost to the profession. Also, since there is so
11 great a demand for general nurses in their own
12 field, and so many attractive offers open to
13 general nurses, when a nurse does obtain this
14 training her services are usually lost to mental
15 hospitals in any case.

16 Paradoxically, a graduate of a general
17 hospital, with no training or experience in
18 psychiatric nursing (or at the most the eight-
19 week affiliation period which is included in the
20 three-year course of general nursing at the present
21 time)), may be placed in a senior position in a
22 mental hospital, over a psychiatric graduate who
23 has taken three years' specialized training, who
24 may have had many years' experience on that
25 particular ward and/or in psychiatric nursing
26 generally, and, who may be expected to "take over"
27 again when the general graduate leaves "for greener
28 pastures". This situation would appear to be
29 brought about by the enviable reputation and well-
30 established recognition general nurses earned long



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Psychiatric, a graduate of a general
hospital, with no training or experience in
psychiatric nursing, as the work is often
very difficult and which is included in the
general course of general nursing at the present
time, may be placed in a general position as a
general hospital, even a psychiatric graduate who
has done some years' specialized training who
may have had many years' experience in that
particular work such as psychiatric nursing
generally, and who may be expected to "take over"
again when the general graduate leaves "the general
position". This situation would appear to be
brought about by the available education and well-
established recognition general nursing's varied long



1 before training programs for psychiatric nurses
2 were established. Nevertheless, if mental hospitals
3 are to be staffed with nursing personnel specifi-
4 cally trained to meet the needs of its patients,
5 it would appear necessary (and fair) to give such
6 personnel full recognition. In the case of male
7 nurses particularly, most of these devote their
8 entire working lives to their calling, although
9 often the very best of these are lured away to
10 other types of work because they have not been
11 given responsibility and remuneration commensurate
12 with those in other specialties with equal train-
13 ing and experience.

14 The above criticism does not refer to gen-
15 eral nurses with recognized courses in psychiatric
16 nursing, who can and do fill essential positions
17 in special areas in mental hospitals.

18 10. In all fairness, it should be pointed out
19 that the general public has been quick to accept psychiatric
20 nursing and to give recognition to this comparatively new
21 line of endeavour. Relatives of mental hospital patients
22 often express gratitude to psychiatric nurses for their
23 good work, as do patients themselves.

1 24 THE CHAIRMAN: Thank you, Mr. Fate. Is
25 it your view and the view of those you represent here to-
26 day that the psychiatric nurse is not interested in having
27 an educational program which would automatically entitle
28 the graduate to be a registered nurse as well as a
29 psychiatric nurse?

30 MR. FATE: Oh, I think yes, I would not



were established. Nevertheless, if mental hospitals
are to be staffed with nursing personnel specifically
trained to meet the needs of the patients,
it would appear necessary (and fair) to give such
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it your view and the view of others you represent here to-
day that the psychiatric nurse is not interested in having
an educational program which would substantially enable
the graduate to be a registered nurse as well as a



1 say that. I think there is a percentage of them that
2 will always be interested in both. However, as a
3 psychiatric nurse and speaking for our Association today,
4 until we can in some manner achieve recognition for the
5 work as a psychiatric nurse, we are going to lose our
6 better nurses to other types of nursing.

7 THE CHAIRMAN: If they become registered
8 nurses?

9 MR. FATE: That is right. A number of
10 them, not all of them certainly but a good number of them
11 we would lose.

12 THE CHAIRMAN: Provided the academic
13 requirement was the same in either case, you have to
14 start from that, position?

15 MR. FATE: Yes.

16 THE CHAIRMAN: What is the proportion of
17 men to women in your operation?

18 MR. FATE: Right now it is just about
19 50-50; we have 64 men and I believe there are 61 women
20 or 62.

21 THE CHAIRMAN: Is it a matter of equal
22 pay?

23 MR. FATE: Yes, they are on an equal pay
24 basis, they take equal training in the course for the
25 psychiatric nurse.

26 THE CHAIRMAN: What is that pay?

27 MR. FATE: At the present time the
28 graduate pay is \$270. a month.

29 THE CHAIRMAN: After the psychiatric
30 nurse graduates where does he or she find employment or



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28 graduate pay is \$270. a month.
29
30 nurse graduates where does he or she find employment or



1 do they remain on the staff of the institution?

2 MR. FATE: The men do. The women, of
3 course, there again you lose the women to the livelihood
4 of women; they are going to be married. If you get a
5 year or two years' service from the women you are
6 fortunate because they leave.

7 THE CHAIRMAN: And does the pay schedule
8 operate then to keep the men in the profession after
9 that?

10 MR. FATE: Yes, I think so. I think it
11 should; I think we should be able to make it worthwhile.

12 THE CHAIRMAN: What is it now? Say a
13 person graduated in 1957 and this is 1962, five years
14 later?

15 MR. FATE: The rate is a maximum of
16 \$345.00 a month.

17 THE CHAIRMAN: That is the maximum?

18 MR. FATE: That is right, that is set by
19 the Government for psychiatric nurses.

20 THE CHAIRMAN: And while taking the course
21 what is the remuneration if any?

22 MR. FATE: They are paid - there is a
23 differential there at present between our fourth year
24 girls and the men, which is what we are teaching in
25 Ponoka. By the fourth year I mean girls taking the
26 two-year course. There are a few who are R.N.'s and we
27 have had one man take the R.N. course.

28 THE CHAIRMAN: What is the pay in the
29 training?

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two-year course. There are a few who are R.N.'s and we

have had one man take the R.N. course.

THE CHAIRMAN: What is the pay in the

training?

MR. FATE: The men at present start at



1 \$230.00 a month and reach \$270.00.

2 THE CHAIRMAN: Two years later?

3 MR. FATE: Three years later. The
4 psychiatric course for men is three years and for women
5 also if they are taking straight psychiatric nursing.

6 THE CHAIRMAN: But if they are going to
7 be registered nurses in Ponoka.

8 COMMISSIONER McCUTCHEON: What are the
9 women paid?

10 MR. FATE: They are paid less, I believe
11 they are paid -- I am not certain but it is less for the
12 girls taking the four-year course.

13 COMMISSIONER McCUTCHEON: What about the
14 three-year course?

15 MR. FATE: They are the same.

16 COMMISSIONER McCUTCHEON: They are paid
17 the same?

18 MR. FATE: Yes, because they are graduate
19 psychiatric nurses.

20 THE CHAIRMAN: After graduation when they
21 remain, to come up to this maximum of \$345.00, does that
22 apply to women as well as men?

23 MR. FATE: That is right, the status is
24 the same in psychiatric nursing.

25 THE CHAIRMAN: What about recruitment?
26 Are there sufficient numbers offering themselves to
27 fill the places that are in these schools for training?

28 MR. FATE: No, I do not feel there are.

29 THE CHAIRMAN: What do you mean by that?
30 Are there vacant places?



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27 fill the places that are in these schools for training?

28 MR. BATE: No, I do not feel there are.

29 THE CHAIRMAN: What do you mean by that?

30 Are there vacant places?



1 MR. FATE: No, we have sufficient at
2 present, but we are attempting to improve our standards
3 and as such we have to get recruits of a category that
4 will meet those standards.

5 THE CHAIRMAN: Are you getting sufficient
6 recruits, men and women?

7 MR. FATE: Yes, I think perhaps in number.

8 COMMISSIONER BALTZAN: Mr. Fate, I under-
9 stand your problems and I have no questions.

10 COMMISSIONER STRACHAN: I was wondering how
11 a psychiatric nurse might come from another province
12 and qualify for work in Alberta. Do you think perhaps
13 they should write an examination?

14 MR. FATE: We hope to eventually, yes, but
15 at present the problems in Manitoba, Saskatchewan, Alberta
16 and B.C. are affiliated and we recognize them.

17 COMMISSIONER STRACHAN: They graduate
18 from there?

19 MR. FATE: Yes, without further examination.
20 We do accept their training program.

21 THE CHAIRMAN: Mr. Fate, are your groups,
22 that is groups in psychiatric nursing, not those that
23 become registered nurse, are they employed in wards in
24 general hospitals, psychiatric nursing?

25 MR. FATE: No, they are not, not as
26 psychiatric nurses.

27 THE CHAIRMAN: If they were employed in
28 general hospitals, what would they be employed as?

29 MR. FATE: With their present training
30 I believe perhaps they would be orderlies, that is the men.



MR. RATE: No, we have sufficient at

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and as such we have to get recruits of a category that

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general hospitals, what would they be employed as?

I believe perhaps they would be orderlies, that is the men.



1 THE CHAIRMAN: Yes, or the women?

2 MR. FATE: I do not know, that would de-
3 pend entirely on ---

4 THE CHAIRMAN: Do you know of any that
5 are employed?

6 MR. FATE: No, not women, but I do know
7 of men that are employed.

8 THE CHAIRMAN: As orderlies?

9 MR. FATE: Yes.

10 THE CHAIRMAN: But not in their capacity
11 as psychiatric nurses?

12 MR. FATE: No.

13 THE CHAIRMAN: But if they have the R.N.
14 qualification then automatically they are --

15 MR. FATE: Oh yes, automatically they are
16 nurses, there is no quarrel about that.

17 COMMISSIONER McCUTCHEON: Does that mean
18 the only field of psychiatric employment is in the govern-
19 ment institutions?

20 MR. FATE: Yes, at present, because of the
21 fact there is our recognition. If, as at present they
22 are building wings for psychiatric treatment in other
23 hospitals, we could go to these places and have recogni-
24 tion as a psychiatric nurse, we would be employed there.

25 COMMISSIONER McCUTCHEON: Why not now?
26 There are psychiatric wards in general hospitals.

27 MR. FATE: Yes, but our training program
28 has not received that recognition that is necessary to
29 qualify us for the pay we are presently receiving in
30 these hospitals if we were to go.



THE CHAIRMAN: Yes, on the way.

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qualify us for the pay we are presently receiving in



1 COMMISSIONER McCUTCHEON: In other words,
2 psychiatric wards in any general hospital in Alberta will
3 not recognize a male nurse having any higher status than
4 an orderly?

5 MR. FATE: That is right.

6 THE CHAIRMAN: They will not pay more
7 than \$345.00 after three years?

8 MR. FATE: No.

9 THE CHAIRMAN: Can you give an answer as
10 to why? If you do not know --

11 MR. FATE: No, I do not honestly know why.

12 THE CHAIRMAN: Well, thank you very much,
13 Mr. Fate.

14 We have word that a Mrs. R.H. Young would
15 like to make a representation at this time.

16 MRS. YOUNG: This is just to clarify this
17 situation. Mr. Fate represents 33% of the employees in
18 the two hospitals, the teaching hospitals in this Province.
19 We are responsible for the total proportion of staff who
20 care for mentally ill in all areas of our Province. Now,
21 we submitted from the two teaching institutes --

22 THE CHAIRMAN: Would you give us your
23 status?

24 MRS. YOUNG: I am Assistant-Superintendent
25 at the Oliver Mental Institute and in co-operation with
26 personnel from the teaching hospitals, I mean Ponoka and
27 Oliver, we submitted to the AARN a very lengthy brief
28 covering the total situation in our psychiatric education
29 and service. Much of this has been incorporated into the
30 AARN Brief.



In other words.

psychiatric wards in any general hospital in Alberta will

not recognize a male nurse having any higher status than

an orderly?

MR. YATE: That is right.

THE CHAIRMAN: They will not pay more

than \$300.00 after three years?

THE CHAIRMAN: Can you give an answer as

to why? If you do not know --

MR. YATE: No, I do not honestly know why.

THE CHAIRMAN: Well, thank you very much.

MR. YATE.

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like to make a representation at this time.

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1 Now, the point is, as of the 1st of
2 February, within our institutions, we have one and a half
3 percent of the registered nursing force in the Province
4 of Alberta responsible for the teaching and a lot of the
5 administration of the total programs which produce people
6 who care for the mentally ill in this Province. There
7 are many, I do not know just how much you want, but there
8 has not been very much included actually in the other
9 presentations this morning of our problems. I was not
10 prepared to speak to this because I felt it would be
11 covered but I feel there are things that should come to
12 the fore at this time..

13 THE CHAIRMAN: You spoke of having pre-
14 pared a rather lengthy brief which went to the Registered
15 Nurses' Association?

2 16 MRS. YOUNG: And much of this has been in-
17 corporated.

18 THE CHAIRMAN: Would you care to file the
19 whole brief that you gave them?

20 MRS. YOUNG: If that is your wish. I
21 think it is a fair picture of the situation.

22 THE CHAIRMAN: If you think it will clarify
23 and give us more information, we will be pleased to have
24 it.

25 THE SECRETARY: That will be Exhibit 131.

26
27 ---EXHIBIT No. 131: Brief Submitted to the
28 Alberta Association of
Registered Nurses.

29 THE CHAIRMAN: Thank you very much Mrs.
30 Young. We will have a short recess and then proceed with



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THE SECRETARY: That will be Exhibit 131.

---EXHIBIT No. 131: Brief Submitted to the
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THE CHAIRMAN: Thank you very much Mrs.

Young. We will have a short recess and then proceed with



1 the brief of the Alberta Association for Retarded Children.

2

3 ---SHORT RECESS

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THE CHAIRMAN: The Brief of the Alberta

Association for Retarded Children will be Exhibit number

132.

---EXHIBIT No. 132: Brief of the Alberta
Association for Retarded
Children

SUBMISSION

Of

ALBERTA ASSOCIATION FOR RETARDED CHILDREN

APPEARANCES:

Miss Winnifred M. Stewart

Mr. A. W. Miller Q.C.

Dr. L. Russell

Mr. Peter Nault

MR. MILLER: Mr. Chairman, and Members of
the Commission, I want to apologize on behalf of the
very charming member of my team who I am going to introduce,
Miss Winnifred M. Stewart, who is founder of the School
for Retarded Children bearing her name. As you are
aware this meeting was called at very short notice and
we find her in her slacks. I hope the Committee will
overlook the fact. When she is prepared for occasions
like this she is really prepared. The next is Dr. Louis



1 the brief of the Alberta Association for Retarded Children

2 ---SHORT RECESS

3 -----

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8 ALBERTA ASSOCIATION FOR RETARDED CHILDREN

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11 Mr. A. W. Miller, Q.C.

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16 aware this meeting was called at very short notice and

17 we find her in her slacks. I hope the Committee will

18 overlook the fact. When she is prepared for occasions

19 like this one is really prepared. The next is Dr. Louis



1 Russell who is President of the Local Association for
2 Retarded Children and Mr. Peter Nault who is a member of
3 the Board of Directors of the Canadian Association for
4 Retarded Children.

5 ~~I think Prof.~~ With your permission, Mr. Chairman, I am
6 going to deviate to a considerable extent from the brief.
7 The brief was prepared by Dr. McCallum, Miss Meikle and
8 Mr. Nault, who is the only one here. I have been asked
9 by the Association on their behalf to present it.

10 ~~Now I want to say~~ May I point out by way of introduction,
11 that up until comparatively recent time the retarded
12 child was the forgotten child. They were kept in the
13 clothes closet. Parents were ashamed to admit they had
14 retarded children. It was only within the last ten
15 years that anyone has shown any interest in the retarded
16 child.

17 I am happy to say that the retarded child
18 has now come out in the open and is being recognized as
19 a human being. In the past ten years, and perhaps less,
20 there have been formed across Canada approximately two
21 hundred schools for the retarded child. There are more
22 than 5,000 pupils attending. Most of those are maintained
23 by voluntary associations. In the Province of Alberta,
24 we have ten schools and one in the process of being opened.
25 That will make a total of ten with an enrolment of 443.
26 In addition, there are in this Province two institutions
27 carried on by the Government of Alberta in the City of
28 Red Deer; one known as the Red Deer Institution and the
29 other the Deer Home Training School with an enrolment of
30 16 to 17 hundred, so that the total in Alberta is over



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27 carried on by the Government of Alberta in the City of
28 Red Deer; one known as the Red Deer Institution and the
29 other the Deer Home Training School with an enrolment of
30 16 to 17 hundred, so that the total in Alberta is over



1 two thousand. One can realize the immensity of the thing.
2 It is interesting and shocking to find that approximately
3 three out of every one hundred children born are retarded.
4 We heard some percentage yesterday in mental health and
5 I think Professor Firestone was shocked at the percentage.
6 These three percent are retarded. I understand a retarded
7 child is born in Canada every twenty-five minutes.

8 Insofar as we in the Province of Alberta
9 are concerned, I must pay due credit to our Provincial
10 Government. They have been very liberal, small "14".
11 We started out as a voluntary organization in 1953 in
12 Edmonton and in the Edmonton Association we had \$3,000.
13 accumulated from various efforts and affairs that we've put
14 on and with the assistance of the public generally, and
15 it is very gratifying, we built a school at a value of
16 about \$150,000.00, all of it by voluntary assistance and
17 donations. So that, insofar as this Province is con-
18 cerned the retarded child is now and has been accepted.
19 Once the matter was brought before the Government, they
20 came to our assistance and with a gradual increase we
21 are now happy to report that they give us the amount of
22 \$640.00 per pupil per year for education. It is far
23 from perfection, but what Government is perfect? We
24 hope someday we may perfect this Government so they will
25 give us approximately \$850.00 a year. The amount we feel
26 it takes to educate a child.

27 THE CHAIRMAN: Have you any comparative
28 figure for the public schools?

29 MR. MILLER: I don't know. Do you, Miss
30 Stewart?



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 9 are concerned, I must pay due credit to our Provincial
 10 Government. They have been very liberal, small.
 11 We started out as a voluntary organization in 1957 in
 12 Edmonton and in the Edmonton Association we had \$5,000.
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 16 about \$150,000.00, all of it by voluntary assistance and
 17 donations. So that, insofar as this Province is con-
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 26 it takes to educate a child.
 27 THE CHAIRMAN: Have you any comparative
 28 figure for the public schools?
 29 MR. MILLER: I don't know. Do you, Miss
 30 Stewart?



1 MISS STEWART: I don't know.

2 MR. MILLER: Considerably more.

3 THE CHAIRMAN: Than \$640.00?

4 MR. MILLER: I am sorry, lower.

5 THE CHAIRMAN: Around \$300.00?

6 MR. MILLER: It is considerably lower be-

7 cause with the retarded child, the ideal class is eight,

8 with a maximum of twelve in them, which is the maximum,

9 and therefore we have to have more teaching staff than

10 we would have in the ordinary school where you can have

11 thirty and forty in a class. In addition, the Government

12 of the Province of Alberta is paying all the capital cost

13 of construction.

14 Now, I might say the \$640.00 grant is

15 assumed by the Government paying 75% and the local school

16 board the other 25%. The capital expense is 90% assumed

17 and paid by the Government and 10% by the local school

18 board, both public and separate because the schools are

19 non-demoninational, non-sectarian.

20 Now, with that introduction may I now go

21 on to speak of the retarded child and for the purpose of

22 the record the retarded child is put into three

23 categories. There is the mild retardation who is

24 educable with an I.Q. generally around 50 to 75 and when

25 mature will reach a mental age of eight to twelve years.

26 They are generally capable of most academic work in the

27 grade two to grade six range, but not beyond. Category

28 two is the moderate retardation, also a trainable in-

29 dividual having an I.Q. reading of twenty to forty-nine.

30 When adult, it will have mental ages of three to seven.



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Now, I might say the \$250.00 grant is assumed by the Government paying 75% and the local school board the other 25%. The capital expense is 90% assumed and paid by the Government and 10% by the local school board, both public and separate because the school's are

Now, when the retardation may I now go on to speak of the retarded child and for the purpose of the record the retarded child is put into three categories with an I.Q. generally around 50 to 75 and when mature will reach a mental age of eight to twelve years. They are generally capable of most academic work in the grade two to grade six range, but not beyond. Category two is the moderate retardation, also a triable individual having an I.Q. reading of twenty to forty-nine. When adult, it will have mental ages of three to seven.



1 They are also generally capable of mastering only the
2 rudiments.

3 THE CHAIRMAN: Mr. Miller, when you talk
4 of age eight to twelve, what is the top age?

5 MR. MILLER: Infinity.

6 THE CHAIRMAN: My understanding...

7 MR. MILLER: You mean the chronological
8 age?

9 THE CHAIRMAN: When you talk in terms of
10 eight to twelve,

11 MR. MILLER: We are talking in terms of
12 mental age. In other words, they will never go beyond.

13 THE CHAIRMAN: What about a person of
14 normal intelligence say with an I.Q. of 100 to 125, what
15 age will that person reach in this same category?

16 MISS STEWART: That depends on the in-
17 dividual.

18 THE CHAIRMAN: Sixteen to seventeen?

19 MISS STEWART: I couldn't say. I don't
20 know, about eighteen.

21 THE CHAIRMAN: These are arbitrary figures.

22 DR. RUSSELL: Sixteen to eighteen.

23 THE CHAIRMAN: When you are talking of
24 twelve you are pretty close.

25 MR. MILLER: I would hate to think I
26 stopped at age twelve, but even with those figures it is
27 60%, if we take eight to twelve.

28 Then, we have the third category, severe
29 retardation, and that is in the range from zero to nineteen,
30 and they reach mental age of zero to two years.



2 Indimensa.

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28 and they reach mental age of zero to two years.



1 Now, the most important thing at the
2 present time is not in the field of education, which, of
3 course, is very, very important, but in the field of
4 research and this is where I think this matter should be
5 given serious consideration insofar as governmental help
6 is concerned, on both levels of government, because we
7 feel that improvements can be made in the retarded child
8 by education, yes, but also by other means. Now, then,
9 during recent years there has been developed what is
10 known as the diaper test. I will refer to Miss Girard
11 as Nurse Girard rather than Miss; Dr. Van Wart and
12 Dr. Baltzan will understand what I am talking about,
13 where the symptoms can be recognized in the very first
14 month of the child's life, and preventive measures can
15 be taken and are successful in checking the disease, if
16 one may call it a disease, before it has had an opportunity
17 of spreading too far.

18 There are various other matters under
19 consideration. As a matter of fact in our own school
20 here in Edmonton, we are, at the present time conducting
21 an experiment with a drug which has been imported from
22 Sweden called siccecell. We are using 66 of our children
23 for that experiment and we conduct what is known as a
24 double blind test. That is no one knows the person -
25 perhaps I am getting ahead of myself - 50% of them are
26 given this medication and 50% are given placebo. The
27 doctors who are conducting this experiment don't know
28 which of the children have got the medication and which
29 has the placebo, only the statisticians attached to the
30 University of Alberta are the ones that will know.



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has the placebo, only the statisticians attached to the
University of Alberta are the ones that will know.



I mention that as one of the matters we might call research because of the expense involved, the drug costs. There are three treatments totalling \$120.00. We must ask the parents to put up that money, and quite a few of them cannot afford it. In addition to that, we must find 33 times \$120.00 because, although we are at the present time collecting \$120.00 from each of the parents, because we don't want them to know which ones are getting the medication and which are not, we will at the end of the experiment refund to them the \$120.00 times 33, money which we will have to raise some way or another. So, I suggest that there is a great need for research.

The education part can take care of itself. We in this Province, I think we are ahead of most of the Provinces in Canada insofar as the support we are receiving from our Government, but we can take care of that. When it comes to the matter of research, it involves many dollars. I happen to be a member of the Scientific Research Advisory Committee of the Canadian Association of Retarded Children. I know our objective is to endeavour to raise \$100,000.00 a year for research only, not for one year, but from year to year. It is our desire and our aim to raise \$100,000.00 for research annually. I think that should be a matter that governmental agencies should be concerned with. Along those lines I would like to make the following recommendations which don't appear in the brief. I didn't prepare this brief and I have ad libbed as I went along.

It is recommended:

1. That the Dominion Government provide special



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2 might call research because of the expense involved, the
3 costs. There are three treatments totalling \$120.00.
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25 agencies should be concerned with. Along those lines
26 I would like to make the following recommendations which
27 don't appear in the brief. I didn't prepare this brief
28 and I have included as I went along.
29 It is recommended:
30 That the Dominion Government provide special



1 grants to the Province that will adequately operate and
2 administer special diagnostic centres for mentally re-
3 tarded and other disabled persons. These diagnostic
4 centres to be fully equipped and manned with the necessary
5 different types of specialized professional personnel, so
6 that any disabled person, whether physical or mental, or
7 both, will receive a complete mental, physical and clinical
8 diagnosis, and, will receive necessary medication and
9 treatment at the time and also "follow-up" treatment.

10 Also, that these diagnostic centres be so
11 administered that the patient can be directed to the
12 specific organization, institution, hospital, etc., in
13 his community that works with his specific type of dis-
14 ability. And, that the special grants provided for the
15 diagnostic clinics, will include the cost of the diagnosis,
16 the treatments and the follow-up medications that are
17 necessary for the health and well being of the disabled
18 person.

19 It is also recommended:

20 2. That Research grants be made available to
21 the Province for these Diagnostic Clinics to carry out
22 research in conjunction with other Research centres
23 in the Dominion, for the purpose of determining the cause
24 of Mental Retardation; and, the effects of specific
25 treatments in cases of Mental Retardation.

26 I might say, Mr. Chairman, and members of
27 the Commission, that the Canadian Association are pre-
28 paring a very extensive brief on the whole field of
29 mental retardation and what I am saying today maybe some-
30 what similar to what the Canadian Association are going to



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8 diagnosis, and, will receive necessary medication and
9 treatment at the time and also "follow-up" treatment.
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11 administered that the patient can be directed to the
12 specific organization, institution, hospital, etc., in
13 his community that works with his specific type of dis-
14 ability. And, that the special needs provided for the
15 diagnostic clinics, will include the cost of the diagnosis,
16 the treatment and the follow-up medication that are
17 necessary for the health and well being of the disabled
18 person.
19 It is also recommended:
20 2. That Research grants be made available to
21 the Province for these Diagnostic Clinics to carry out
22 research in the following areas:
23 in the Dominion, for the purpose of determining the cause
24 of Mental Retardation; and, the effects of specific
25 treatments in cases of Mental Retardation.
26 I might say, Mr. Chairman, and members of
27 the Commission, that the Canadian Association are pro-
28 posing a very extensive study on the whole field of
29 mental retardation and what I am saying today maybe some-



1 submit to the Board. I have a draft of it. It isn't in its
2 completed form yet. We are still working on the principal
3 brief, which, I believe, will be submitted to the Commission
4 in Ottawa in March.

5 THE CHAIRMAN: March 19th.

6 MR. MILLER: I think that is the date,
7 sir, so with these few remarks that I want to make here
8 today, I think that anything further that could and should
9 and will be said on behalf of the retarded child, will be
10 contained in the Canadian Association brief.

11 I want to thank you, and if there are any
12 questions any member of my team will endeavour to answer
13 them.

14 THE CHAIRMAN: Thank you very much,
15 Mr. Miller. As you will appreciate the more complete
16 development of this whole subject will follow this sub-
17 mission of the National brief at Ottawa.

18 ~~Miss Stewart:~~ have you something to add?

19 MISS STEWART: No, I don't think so.

20 THE CHAIRMAN: These ten or eleven schools,
21 how are they dispersed throughout the Province? I don't
22 want to know exactly where they are.

23 MISS STEWART: There is one in Lethbridge,
24 Calgary, Medicine Hat, Red Deer, Hinton, Edmonton,
25 Vermillion, Vegreville, Drumheller, and Grande Prairie.

26 THE CHAIRMAN: The distribution is fairly
27 wide?

28 MR. MILLER: Fairly wide.

29 THE CHAIRMAN: Quite widely spread?

30 MISS STEWART: Yes sir.



1 submit to the Board. I have a draft of it. It isn't in its
 2 completed form yet. We are still working on the preliminary
 3 brief, which, I believe, will be submitted to the Commission
 4 in Ottawa in March.

5 MR. MILLER: I think that is the date.
 6 All right, so with these few remarks that I want to make here
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13 THE CHAIRMAN: Thank you very much.
 14 Mr. Miller. As you will appreciate the more complete
 15 development of this whole subject will follow this ad-
 16 mission of the National Brief at Ottawa.
 17 Mr. Stewart, have you something to add?

18 THE CHAIRMAN: These ten or eleven schools
 19 how are they distributed throughout the Province? I don't
 20 want to know exactly where they are.

21 MISS STEWART: There is one in Lethbridge,
 22 Calgary, Medicine Hat, Red Deer, Wainwright, Edmonton,
 23 Vermilion, Vegreville, Drumheller, and Grande Prairie.
 24 THE CHAIRMAN: The distribution is fairly



1 THE CHAIRMAN: Have you any difficulty
2 in getting teachers?

3 MISS STEWART: Yes, I think that the
4 teachers, these people have to be trained, specially
5 trained personnel, and this is a difficult thing, to be
6 able to get teachers who are trained in this work.

7 THE CHAIRMAN: Where are these teachers
8 trained?

9 MR. MILLER: We train our own teachers
10 at our own school.

11 THE CHAIRMAN: The development has been
12 of too short a duration to have built up ...

13 MR. MILLER: May I say too, Mr. Chairman,
14 in regard to teachers, what we are looking for are not
15 teachers as such, but devoted teachers. That is a person
16 who has a feeling for and interest in the retarded child.
17 For example our craft teacher has left a much higher paying
18 position to come and teach at our school. As I say we
19 are not looking for teachers as teachers, but dedicated
20 persons, as they must have some feeling towards the re-
21 tarder child.

22 THE CHAIRMAN: Dr. Russell, is there
23 anything you wish to add?

24 DR. RUSSELL: We do have the problem of
25 development of workshops, the eventuality for these
26 children. We are probably supplying the proper work-
27 shop facilities at the present time, but the graduation
28 from our school system into the workshop setup is some
29 thing that has to be developed in the future and which
30 will be quite a large expense, which we also feel should



MISS ALLEN: Yes, I know that.

Teachers, these people have to be trained, they have to be trained personnel, and there has to be a certain amount of training to be able to get teachers who are trained in this work.

MR. WILSON: We would like to see this

at our own school.

THE CHAIRMAN: The question is, is it

of too short a duration to be of any use?

MR. WILSON: Yes, I think it is.

in regard to personnel, and we are going to have to

teachers as such, but they are not going to be

who have a feeling for the children in the classroom.

For example our craft program, we are going to have

position to come and work at our school. As I say we

are not looking for teachers as teachers, but looking for

persons, as they must have some feeling towards the

THE CHAIRMAN: Mr. Wilson, is there

anything you wish to say?

MR. WILSON: Yes, I have a problem.

development of work habits, and the children get these

children. We are probably overlooking the proper form

shop facilities at the present time. But the graduation

from our school system into the working world is a

thing that has to be developed in the time and which

will be quite a large expense, which we also should



1 be borne by the Government.

jb 2 THE CHAIRMAN: What about the graduation
3 from the workshop into the community?

4 DR. RUSSELL: The same thing.

5 THE CHAIRMAN: Mr. Nault?

6 MR. NAULT: I believe that anything I
7 might add will be brought before your Board in Ottawa
8 in March on the C.R.C. brief, because I am the same as
9 Mr. Miller. I have a copy that came out yesterday, and
10 the official one will fill in everything.

11 COMMISSIONER GIRARD: Mr. Miller, or
12 Miss Stewart, how wide spread is the test for phemylke-
13 tonuria in this Province? Is it done routinely in well-
14 baby clinics or in hospitals?

15 MISS STEWART: This, I could not say.
16 I am sure that most of the doctors, the child specialists,
17 do carry out these tests, and I think the doctors do
18 know about this. In fact, I am sure they do.

19 COMMISSIONER GIRARD: We were told in
20 some provinces that it was becoming routine, and they
21 claim they can find only one in 25,000, but still that
22 one is very important.

23 MR. MILLER: I believe the same situation
24 exists in this Province. It is becoming more and more
25 prevalent.

26 COMMISSIONER GIRARD: A routine test?

27 MR. MILLER: Yes.

28 THE CHAIRMAN: Routine in the hospital?

29 MR. MILLER: Routine in the hospital, yes.

30 COMMISSIONER GIRARD: In well-baby clinics?



be borne by the Government.

THE CHAIRMAN: Now about the graduation

from the workshop into the community?

THE CHAIRMAN: Mr. Miller?

MR. MILLER: I believe it's something I

might add will be brought before your Board to discuss

in March on the C.R.C. matter, because I am the same as

Mr. Miller. I have a copy that came out yesterday, and

the official one will fill in something.

COMMISSIONER: Now, Mr. Miller, on

Miss Stewart, now who agreed to be the

towns in this Province. Is it true, or is it not?

body either on in hospital?

MISS STEWART: Yes, I could not say.

I am sure that most of the women, the other hospitals,

to carry out these cases, and I think the women are

know about this. In fact, I am sure they do.

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COMMISSIONER: Now, Mr. Miller, a positive test

THE CHAIRMAN: Now, Mr. Miller, a positive test

MR. MILLER: Now, Mr. Miller, a positive test

MR. MILLER: Now, Mr. Miller, a positive test



1 MR. MILLER: I do not know about well-
2 baby clinics, but in the hospitals --- Mrs. Sabin of
3 the A.A.R.N. says it is routine in the well-baby clinic.

4 COMMISSIONER GIRARD: Yes, thank you.

5 MR. MILLER: My nurses are still back of
6 me!

7 THE CHAIRMAN: Thank you very much,
8 Mr. Miller.

9 As I said a few moments ago, this matter
10 will receive much more detailed examination and full
11 consideration when we have heard the National Brief.

12 MR. MILLER: Thank you very much for
13 giving us the opportunity of presenting our case to you.

14 THE CHAIRMAN: We are very grateful to
15 you for coming along out of turn to fill in. It was a
16 matter of great accommodation to the Commission.

17 MR. MILLER: Thank you.

18 THE CHAIRMAN: We shall recess now until
19 2:00 p. m.

20

21 ---LUNCHEON ADJOURNMENT

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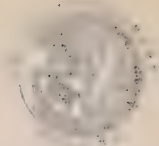
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MR. MILLER: I do not know about water-

the A.A.R.M. says it is routine in the well-baby clinic.

COMMISSIONER GORDON: Yes, thank you.

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you for coming along out of town to fill in. It was a

matter of great accommodation to the Committee.

MR. MILLER: Thank you.

THE CHAIRMAN: We shall receive you again.

2:00 p. m.

---LUNCHEON ADJOURNMENT



1 ---Upon resuming.

2

3 THE CHAIRMAN: The submission of the
4 Alberta Psychiatric Association. Dr. Guild.

5

6

---EXHIBIT NO. 133: Submission of the Alberta
Psychiatric Association.

7

8

SUBMISSION OF

9

ALBERTA PSYCHIATRIC ASSOCIATION

10

APPEARANCES:

Dr. J. Guild

11

Dr. W. Forster

12

Dr. K. Yonge

13

Dr. A. N. McTaggart

14

Dr. A. R. Schrag

15

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18

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23

DR. GUILD: Thank you, Mr. Chairman. We
of the Alberta Psychiatric Association welcome the
opportunity of presenting the brief to you, because in
the first place we have welcomed the opportunity of the
appointment of the Commission because it has given us the
occasion to have a look at ourselves and give our branch
of medicine some study. This, in itself, is a very
salutary situation, we feel.

24

25

26

Those at the table with me are representa-
tives of our Association: Dr. Forster, Dr. Yonge,
Dr. McTaggart and Dr. Schrag.

27

28

29

30

While we are all on the staff of the
University of Alberta, and while of us represent or work
in provincial services, and Dr. Yonge is chairman and head
of the Department of Psychiatry at the University, we do



1 ---Upon receiving.

2 THE CHAIRMAN The members of the

3 Alberta Psychiatric Association, Dr. Guild.

4 Substitution of the Alberta
Psychiatric Association.

5 ---EXHIBIT NO. 133.

6
7
8
9

10 APPENDIX:
11 Dr. J. Guild
12 Dr. W. Young
13 Dr. R. Young
14 Dr. A. Young
15 Dr. A. Young

16 Dr. GUILD: Thank you for the information. We
17 of the Alberta Psychiatric Association were one of the
18 opportunity of presenting the matter to you, because in
19 the first place we have received the opportunity of the
20 appointment of the Commission because it has given us the
21 occasion to have a look at ourselves and also our present
22 of medicine some study. That in itself is a very
23 salutary attention, we feel.

24 Those at the table with me are representatives

25 Dr. McTaggart and Dr. Schrag

26 While we are all on the staff of the

27 University of Alberta, and while of us represent or work

28 in provincial services, and Dr. Young is chairman and head

29 of the Department of Psychiatry at the University, we do



1 not speak here as members of these separate bodies. Rather,
2 our views are those of the Psychiatric Association. We
3 would like to feel that we are speaking independently as
4 an association, and while we are part of the medical
5 profession and we have close ties with the Canadian
6 Psychiatric Association, the preparation of this submission
7 is an independent affair. We are gratified to see our
8 views are so similar to the views of other similar
9 associations across the country.

10 We appreciate, Mr. Chairman, that Dr.
11 Richmond and Dr. Canacher will be making particular
12 studies of the psychiatric situation in the country.
13 However, we would welcome any questions which you have and
14 we can assure you that not everything you say will be
15 analyzed.

16 The Alberta Psychiatric Association is
17 incorporated under the Friendly Societies Act, and we are
18 the sole organization representing psychiatrists in this
19 province.

20 With your permission, I should like to read
21 the statement of general principles and the summary of
22 recommendations.

23 I. GENERAL PRINCIPLES

24 1. Psychiatry has for too long been considered on or
25 even beyond the periphery of medicine. For this
26 reason the views contained in this brief were
27 expressed in the first instance through the
28 College of Physicians and Surgeons of this Province.
29 This brief is being submitted separately however,
30 in order to give adequate attention to those areas



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9 associations across the country.
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12 studies of the psychiatric situation in the country.
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27 expressed in the form of a statement through the
28 College of Physicians and Surgeons of the Province.
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1 which extend beyond the usual scope of medicine,
2 bur form an integral part of the practice of
3 psychiatry. Such areas as social welfare,
4 education, child care, social delinquency, and
5 the social behaviour of humans must remain fields
6 in which psychiatry has a continuing interest,
7 and an involvement which complements its role
8 in medicine.

9 2. Complete mental health services (prevention,
10 treatment and rehabilitation) should be available
11 to everyone geographically and financially, and
12 for all areas of need, as an integral part of the
13 practice of medicine.

14 3. Continuity of treatment (in-patient and out-
15 patient) as well as mutual freedom of choice
16 between patient and doctor should be assured
17 whenever possible. A sense of independence and
18 responsibility for his own health care is an
19 important element in the patient's therapy.

20 4. Psychiatric patients should be given care in
21 keeping with their needs and be accorded equal
22 status with other kinds of patients. All programs
23 should include psychiatrists and their patients
24 on an equal footing with all other physicians
25 and patients. Hospital facilities for the actue
26 and continued treatment of psychological disorders
27 should be included in the present federal-
28 provincial hospital fiscal program and there
29 should be a uniform system of administration
30 and financing for all types of hospitals.



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status with other kinds of patients. All patients
should include psychiatrists and their patients
on an equal footing with all other patients
and patients, hospital facilities, or the state,
and continued treatment or psychological assistance
should be included in the present hospital-
provisional hospital, local program and state
should be a uniform system of administration
and financing for all types of hospitals.



5. The remuneration and conditions of work of personnel providing mental health service should be equal to those in other specialties with equal training and experience. Remuneration should increase with increasing training, skill and experience.
6. Organized research should be provided on an adequate level into all aspects of mental health and mental disorder. Long term research is especially important.
7. An active educational program is required covering
 - 1) the general public and
 - 2) all medical and ancillary health, welfare and educational personnel (e.g. nurses, probation officers, social workers).

II. SUMMARY OF RECOMMENDATIONS

8. All mental hospital facilities should be included with all other types of hospital facilities in a uniform system of administration and finance, and the areas served by the existing mental hospitals should be reduced as soon as possible and other areas of the province should be cared for by Regional psychiatric hospital facilities in the Cities of Edmonton, Calgary, Lethbridge and Grande Prairie associated with general hospitals in those areas.
9. In addition to these Regional Centers, and especially in the interim pending their development, psychiatric units should be developed in general hospitals in the larger urban areas.



The remuneration and conditions of work of personnel providing mental health services should be equal to those in other occupations with equal training and experience. Remuneration should increase with increasing training, skill and experience. Organized research should be provided on an adequate level for all aspects of mental health and mental disorders. Long term research is especially important. An active research program is required covering (1) the general public and (2) all mental and physical health, welfare and educational problems (e.g. nurses, psychiatric officers, social workers).

II. SUMMARY OF RECOMMENDATIONS

8. All mental health facilities should be integrated with all other types of hospital facilities in a national system of administration and financing. The areas served by the existing mental hospitals should be reduced to areas as possible and other areas of the country should be served by regional general hospitals. Regional general hospitals should be in the areas of education, health, labor, and social affairs associated with general hospitals in the areas. In addition to these regional centers, and especially in the interim pending their development, psychiatric units should be located in general hospitals in the larger urban areas.



10. Establishment of day hospital and night hospital facilities in regional psychiatric centers, and in psychiatric units in general hospitals.
11. Expansion of services in a regional center for:
 - 1) In-patient care of children with emotional disturbances.
 - 2) In-patient care of children with mental retardation.
 - 3) Children with brain damage and sensory deprivation.
 - 4) In-patient care of adolescents with emotional disturbance.
 - 5) Child Guidance Clinics.
12. Psychiatrists practising in the community should be provided with opportunities for taking part in the work of the regional psychiatric center, and full time psychiatrists in this center should be provided with opportunities for extending their work into the community and private practice.
13. Psychiatric services would best be provided through a universally available pre-paid medical insurance scheme giving unrestricted psychiatric coverage. Doctors may participate in the scheme on a fee-for-service basis, a part time sessional indemnity basis or on a full time salary. Income should be comparable regardless of the method of payment.
14. All hospitals facilities in a given area should be the administrative and financial responsibility of a regional hospital authority to whom employed physicians are responsible.



10.	Establishment of day hospital and night hospital facilities in regional psychiatric centers, and in psychiatric units in general hospitals.	1
11.	Expansion of services to a regional center for: 1) In-patient care of children with emotional 2) In-patient care of children with mental 3) Children with chronic disease and epilepsy 4) In-patient care of adolescents with emotional 5) Child Guidance Clinics	2
12.	Psychiatric training in the community should be provided with opportunities for taking part in the work of the regional psychiatric center, and full time psychiatrists in this center should be provided with opportunities for research work.	3
13.	Psychiatric units or wards need be provided through a university, or through pre-paid medical insurance, or through other means.	4
14.	Doctors may participate in the scheme of a fee-for-service basis, or on the basis of a salary, or on a fixed time salary. Income should be comparable regardless of the method of payment.	5
	All hospital facilities in a given area should be the administrative and financial responsibility of a regional hospital authority to whom employed	6



- 1 15. Expansion of the psychiatric training program for
2 doctors and nurses.
- 3 16. Establishment of a School of Social Work, and of
4 Clinical Psychology in the Province.
- 5 17. Coordination of the services of voluntary social
6 agencies, the Alcoholism Foundation, and the
7 Canadian Mental Health Association with the
8 regional psychiatric centers.
- 9 18. Provision of services for epileptics, sociopaths,
10 sexual deviates, juvenile offenders and criminals.
- 11 19. Special study should be given to the problems of
12 sociopaths, sexual deviates, drug addicts, and the
13 disabled, with a view to establishing special
14 legislation in these areas.
- 15 20. Provision of medication free or at nominal charge
16 to epileptic and psychologically ill patients who
17 cannot afford them.
- 18 21. Coordination of psychiatric treatment in the
19 Children's Aid Departments with the regional
20 psychiatric centers.
- 21 22. Establishment of disablement register and of
22 hostels for disabled persons.
- 23 23. Economic support for White Cross Centers, and
24 extension for services for problem drinkers.
- 25 24. Improvement of vocational training in high schools,
26 and vocational training for rehabilitation,
27 involving consultation among the various agencies
28 concerned.
- 29 There is one erratum, Mr. Chairman. On the
30 last page, page 14, paragraph 89, line 5: That should



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Improvement of vocational training in high schools,	24.
and vocational training for rehabilitation,	
involving consultation among the various agencies	
concerned.	
There is one error, Mr. Chairman. On the	
last page, page 14, paragraph 22, line 5: That should	



1 read: "Medical Research Council" rather than "Provincial
2 Research Council".

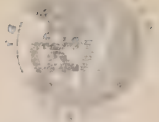
3 THE CHAIRMAN: Thank you, Dr. Guild.

4 COMMISSIONER BALTZAN: May I just say this,
5 Mr. Chairman. It grieves me to have to pass up such a
6 grand opportunity of getting some free information. My
7 questions are entirely academic and statistical and non-
8 psycho-analytical. The reason I do not ask you any
9 questions -- you would probably go and say to me, "Why
10 don't you go and buy yourself a couple of books".

11 For that reason, I will be glad to listen
12 to you, and thank you very much.

13 COMMISSIONER FIRESTONE: Dr. Guild, I take
14 it the psychiatric services serve human objectives,
15 humanitarian objectives, in trying to help the patient
16 get well and to enable him to play his proper part in his
17 family and in his community. I wonder whether psychiatric
18 services also serve economic objectives, to help a person
19 getting well to enable him to increase his productivity
20 and perhaps to reduce losses to society as the result of
21 lost time because of mental ill health. I wonder whether
22 I can ask a few questions as to the economic impact of
23 psychiatric services.

24 Do people with mental disorders -- does
25 that affect them as far as their ability to work is
26 concerned, either by reducing their productivity, lost
27 time during the work week, et cetera? I would like to
28 relate the services which you render to the economic
29 benefit that accrues not only to the patient and family
30 and community, but to society as a whole.



1 Read: "Medical Research Council" paper from "Psychological
2 Research Council".

COMMISSIONER EASTMAN: Now I just say this.

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Do people with mental disorders -- does

that affect them as far as their ability to work is
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benefit that accrues not only to the patient and family
and community, but to society as a whole.



1 with an expert DR. GUILD: I think the question has to be
2 broken down into two parts. It is often said that a good
3 proportion of the population does suffer from minor
4 psychiatric disorder or emotional discomfort which would
5 not be considered, perhaps, clinical disorder. For these
6 people, it would be very difficult for us to give you
7 very much of a figure, and it may not be that these people
8 have too much of a detriment in their economic function.

9 Unintentionally. I think it is true that people who do have
10 continued mild or severe or acute, intense or moderate
11 degrees of disorder do suffer in their capacity to
12 contribute to society and their families.

13 COMMISSIONER FIRESTONE: Now, in the
14 Province of Alberta, sir, would you be able to tell us
15 approximately what magnitude we are talking about in terms
16 of people who have these sort of problems you have
17 described that would affect their productive capabilities?

18 DR. GUILD: The only figures we can give
19 you, and I am not sure we have all of them at hand, would
20 be to tell you of the number of patients who consult
21 psychiatrists privately, and those who come to the guidance
22 clinics and those admitted to the hospitals. We have not
23 got, I think, an aggregate figure. We can give you an
24 approximate figure. There are nearly 3,500 patients in
25 the mental hospitals in this province so far, at this time.
26 There is an annual admission to the mental hospitals in
27 this province of approximately 1,000 patients. We can
28 give you, if you wish, exact figures and can submit them
29 to you subsequently.

30 COMMISSIONER FIRESTONE: We are not concerned



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psychiatric disorder or emotional discomfort which would
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approximate figure. There are nearly 5,000 patients in

the mental hospitals in this province as at this time

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this province of approximately 1,000 patients. We can

give you, if you wish, exact figures and can submit them

to you subsequently.

COMMISSIONER FIRESTONE: We are not concerned



1 with an exact figure; we just want to assess a little
2 bit the dimensions of the problem, and if increased
3 action will be taken what benefit will accrue from it,
4 or an approximation is fully adequate for the purpose at
5 hand at the moment.

6 DR. GUILD: Yes. In addition to the mental
7 hospitals, of course, there are the two psychiatric units
8 in general hospitals. There are 52, roughly, beds in the
9 University Hospital in Edmonton; about 20 in hospital in
10 Calgary and about 20 in another. I cannot give you figures
11 for the hospital in Calgary. Our beds are kept filled
12 almost to maximum capacity. That would be somewhere over
13 90%, certainly, for an average length of stay of some where
14 about three weeks, or slightly more.

15 I suppose if pressed for a figure I might
16 say that perhaps there are at this time or in the course
17 of a year possibly 5,000 or 6,000 people who are treated
18 by psychiatrists.

19 COMMISSIONER FIRESTONE: Well, this is
20 very helpful and a very good beginning, sir. I presume
21 there will be other people with similar disorders that are
22 not treated by a psychiatrist. Would they be more numerous
23 than those treated, or less; or, is this information
24 available?

25 DR. GUILD: The information is not available,
26 but there is considerable reason to believe that many of
27 the patients who consult a variety of physicians in other
28 branches of medicine do so for disorders which have
29 associated with the physical disorder emotional problems,
30 or emotional problems may be the very root of the physical



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1 symptoms which they have. This number would be considerably
2 greater than frank psychiatric problems.

3 COMMISSIONER FIRESTONE: Would this second
4 group of people which you have mentioned with severe
5 emotional problems; people who consult their family doctors,
6 and other general practitioners, would they also be
7 affected in their productive capabilities? Would emotional
8 disorders of this type affect the ability to produce?
9 Would it contribute to absenteeism; would it contribute
10 to producing less than somebody else who is not disturbed?

11 DR. GUILD: There can be no doubt about
12 that.

13 COMMISSIONER FIRESTONE: What you are saying,
14 sir, is that while the program that you are proposing
15 may involve a considerable amount of money, the return
16 which society would get not only in improved human welfare
17 but in terms of increased productivity by the people who
18 would get well would be considerably in excess of the
19 investment that is required to extend psychiatric services
20 in the Province of Alberta. Is that the point you are
21 making?

22 DR. GUILD: That is one of our central
23 beliefs.

24 COMMISSIONER FIRESTONE: Thank you very
25 much.

26 Coming to the second point of how you would
27 achieve this service, I think you have said so in paragraph
28 13 of your submission on page 2. You recommend in this
29 paragraph that psychiatric services would best be provided
30 through a universally available pre-paid medical insurance



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22 DR. GULLIN: That is one of our central
23 points.
24 Coming to the second point of how you would
25 achieve this service, I think you have said so in paragraph
26 13 of your submission on page 2. You recommend in this
27 paragraph that psychiatric services would best be provided
28 through a universally available pre-paid medical insurance



1 scheme giving unrestricted psychiatric coverage.

2 Could you explain to the Commission what
3 you mean by a universally available pre-paid medical
4 insurance scheme as applicable to Alberta?

5 DR. GUILD: Our views on this are identical
6 with those of the medical profession which were represented
7 in a brief by Dr. Thomson a couple of days ago.

8 COMMISSIONER FIRESTONE: Well, could you
9 express it in your own words, sir?

10 DR. GUILD: Yes, we believe the people
11 should have, certainly, because of the therapeutic
12 advantage, a sense of personal responsibility in contri-
13 bution to the treatment of their disorders and that this
14 is best done through a pre-paid insurance scheme voluntarily
15 assumed. We feel that such a scheme should have, in order
16 to give the best service, should have no limitations either
17 as to time or procedure so long as those procedures are
18 recognized psychiatric procedures.

19 COMMISSIONER FIRESTONE: Now, if the
20 Province of Alberta were to introduce a voluntary pre-paid
21 medical insurance plan to which the Federal Government,
22 just taking a figure out of the air, would contribute 50%
23 and assuming that this plan would provide that it would
24 cover full and unrestricted psychiatric coverage as
25 recommended in your brief, would you association support
26 such a plan?

27 DR. GUILD: I am not sure what the Federal
28 contribution would go towards. We feel that as Doctor
29 Thomson's committee has felt that assistance is provided
30 or is needed rather for probably a small section of our



Could you explain to the Commission what

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and assuming that this plan would provide that it would

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recommended in your brief, would you anticipate requiring

such a plan?

DR. QUILL: I am not sure what the Federal

contribution would go towards. We feel that a hospital

Thomson's committee has felt that assistance is provided

or is needed rather for probably a small section of our



1 community and I am not sure where that 50% the Government
2 would provide would go.

3 COMMISSIONER FIRESTONE: Let us assume that
4 the plan would be based on the principle that those who
5 can afford to pay for it do pay for it and those that
6 cannot afford to pay for it either in full or in part have
7 their premiums or equivalent paid by the State. Assuming
8 further that the Province of Alberta may feel that the
9 amounts involved are unusually large and the Federal
10 Government therefore contributes to that part of the
11 programme a 50% contribution; does that answer the question
12 in your mind?

13 DR. GUILD: Yes.

14 COMMISSIONER FIRESTONE: Assuming this was
15 the plan, how would the Association feel?

16 DR. GUILD: I think we would go along with
17 this providing the independence of the profession in pro-
18 viding a service could be maintained and providing that
19 some carrier such as M.S.I. would be available in the
20 province.

21 COMMISSIONER FIRESTONE: In other words,
22 what you are saying is if such a plan were administered
23 by a carrier such as M.S.I. being nominated as a designated
24 carrier by the Province of Alberta to administer such a
25 plan which gives the medical profession an opportunity to
26 have a major say in the development and administration of
27 the plan?

28 DR. GUILD: Yes, with this proviso, of
29 course, that the psychiatrist would not have any different
30 arrangement than the rest of the medical profession would



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2 COMMISSIONER FIRESTONE: You could not
3 visualize that there may be differences of detail as to
4 the sort of arrangements since you have emphasized some
5 special needs.

6 DR. GUILD: We feel that the very important
7 thing is universal coverage or the availability. Once
8 this is accomplished I do not think it is for us to go
9 into the intricacies of the economic detail because we
10 are not qualified to do that. I would suggest, though,
11 that we cannot see why provision could not be made under
12 one general scheme acceptable to the whole medical pro-
13 fession which would not fit us. We feel a central scheme
14 would be all inclusive, it should be possible with human
15 ingenuity to work these things out.

16 COMMISSIONER FIRESTONE: I am very encouraged
17 by you saying this. Have any of your colleagues anything
18 to add? Fine, thank you very much.

19 COMMISSIONER BALTZAN: I just want to pose
20 something for you; it has been said and I quote:

21 "Thank God for the neurotics, they use their
22 "imagination most."

23 Is that a derisive statement or is there considerable merit
24 in this statement?

25 DR. GUILD: I hesitate to answer that
26 because I do not know of whom in this room I would be
27 speaking. Many of us hold the view that some degree of
28 neurosis is extremely wide spread and I think we all like
29 to consider ourselves, in a constructive way, imaginative
30 people.



I have.

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because I do not know of whom in this room I would be speaking. Many of us hold the view that some degree of neurosis is extremely widespread and I think we all like to consider ourselves, in a constructive way, imaginative people.



1 COMMISSIONER BALTZAN: You have answered
2 both sides of my question.

3 COMMISSIONER STRACHAN: I am thinking of
4 the presentation yesterday by the teachers' group wherein
5 they suggest that neither parent nor teachers could
6 recognize mental disturbances at an early enough age. I
7 think I am correct when I say they recommended that
8 psychiatrists should check the school population. What is
9 your opinion of this? What would be the personnel that one
10 psychiatrist could take care of and check within a given
11 time?

12 DR. GUILD: I would refer that to the
13 director of our Provincial Guidance Clinic, Dr. Schrag.

14 DR. SCHRAG: I think there are several
15 ways of answering this question. I think that this is
16 part of the general educational programme that must be
17 carried out. I would take exception to the statement of
18 the teachers that this must be the function of a psychiatrist;
19 I think a psychiatrist, as we are working, in co-operation
20 with the so-called visiting teachers and the Edmonton
21 School System.

22 THE CHAIRMAN: I think the statement was
23 someone with psychiatric training.

24 COMMISSIONER STRACHAN: Competent psychiatric
25 training.

26 DR. SCHRAG: I think it is accomplished in
27 the Cities of Edmonton and Calgary with visiting teachers
28 working in close relationship with the guidance clinics
29 both north and south and the guidance clinic programme is
30 working in close co-operation with the schools in rural

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1 areas. We feel this should be extended. Have I answered
2 your question?

3 COMMISSION VAN WART: In section 54, just
4 an explanation:

5 "Consideration should be given to the

6 "Gheel system ---"

7 Would you say a few words about that system?

8 DR. GUILD: We would be glad to provide the
9 Commission, if you so wish, with detailed references
10 elaborating on this. This is a European, a Belgian system
11 where patients are boarded out in the community from the
12 mental hospitals and are looked after in the community in
13 family settings.

14 COMMISSIONER VAN WART: With trained help
15 in the boarding places?

16 DR. GUILD: No, it is, if you like, a foster
17 home.

18 COMMISSIONER VAN WART: The person in charge
19 of the home has had no special training?

20 DR. GUILD: An attempt, of course, is always
21 to provide as normal and mature a home as one can select
22 but the emphasis is on an average, normal every-day home
23 in the community. This would not be, of course, for acute
24 patients, it would be patients that are convalescent.

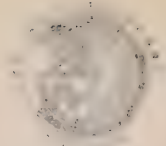
25 COMMISSIONER VAN WART: I understand that.
26 Then, section 55:

27 "Day and night hospitals have proven to be

28 "a very effective method of instituting

29 "treatment for both neurotic and psychotic

30 "states ---"



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1 Would you elaborate a little?

2 DR. GUILD: Yes, about 1944 beginning at
3 McGill in Montreal, Dr. Cameron instituted the programme
4 of day hospitals in which patients would go to the hospital
5 at eight o'clock or thereabouts in the morning and go home
6 somewhere around four or five o'clock in the afternoon.
7 In this way they maintained contact with the community
8 which is disrupted when a person had to be in hospital
9 24 hours. At the same time this makes available to them,
10 in selected and suitable cases, the treatment facilities
11 of the hospital during the daytime. This includes almost
12 all treatment facilities that we would normally have in
13 the field of psychiatry.

14 Night hospitals are the same thing turned
15 about, the patients would be able to go out to work during
16 the daylight hours and get their treatment in the hospitals
17 in the evening and they would have the advantage of a
18 protected setting pending their recovery during the night
19 time.

20 COMMISSIONER VAN WART: Have the hospitals
21 of Alberta staff and so on to give treatment such as you
22 are suggesting here?

23 DR. GUILD: Could I refer that to Dr. Yonge?

24 DR. YONGE: At present this principle is
25 practised only in individual cases, there is no organization
26 for a day service or a night service. This would involve
27 extra staff, certainly for instance the evening treatment.
28 Perhaps it would not be useful to quote figures about staff
29 unless we had some concept of how large a service this
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1 COMMISSIONER VAN WART: Would such a
2 service be desirable?

3 DR. YONGE: I think it would be highly
4 desirable not only that it would provide services as
5 adequate for selected patients as 24-hour services but it
6 would in the long run be much more economical as far as
7 the hospital is concerned. This system has been well
8 worked out in the Montreal General Hospital where their
9 psychiatric department has three organizations, three
10 processes, one ward looks after patients much as most
11 other hospitals do with a 24-hour coverage. Another section
12 of the ward is given over to both the day and night areas
13 so that this other section, the second section I referred
14 to handled twice the number of patients that its bed
15 capacity would allow and sometimes by ingenuity even three
16 times.

17 COMMISSIONER VAN WART: Better utilization
18 of your equipment?

19 DR. YONGE: Yes. Now, this should not infer
20 that the single shift of staff can cover all of this, it
21 does require some increase in staff but not proportionately
22 to the 24-hour service.

23 DR. GUILD: I wonder if I might just add
24 one or two things which we feel are important within the
25 deliberations of the Commission. These have to do with
26 statistics and one is the concept of the re-admission rate
27 as it exists today. In the Dominion Bureau of Statistics
28 the re-admission rate is reckoned on the number of admissions
29 and patient returns to the hospital. Each time that
30 patient returns he is re-admitted and in point of fact the

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other hospitals do with a 24-hour coverage. Another section

of the ward is given over to both the day and night areas

so that with other sections, the second section I referred

to handled twice the number of patients that the bed

capacity would allow and sometimes by ingenuity even three

times.

COMMISSIONER VAN WART: Better utilization

of your equipment?

DR. YONGE: Yes. Now, this should not infer

that the single shift of night and cover all of this, it

does require some increase in staff but not proportionately

to the 24-hour service.

DR. GUILD: I wonder if I might just add

one or two things which we feel are important within the

deliberations of the Commission. There have to do with

statistical and one in the concept of the re-admission rate

as it exists today. In the Dominion Bureau of Statistics

the re-admission rate is reckoned on the number of admissions

and patient returns to the hospital. Each time that

patient returns he is re-admitted and in point of fact the



1 figure is fallacious and excessive because the patient
2 may return on subsequent occasions for treatment of the
3 same condition which was intended when he first came in.
4 I think in your deliberations the meaning of these figures
5 should be taken into account.

6 Secondly, we have often suggested and would
7 like to put this before this Commission that we require
8 statistically two kinds of information about patients;
9 one is the sickness experience of a single individual over
10 a lifetime and the other is the sickness experience in
11 the general population at any given time. This means we
12 would require card catalogues, if you like, of individual
13 patients each time they are admitted, each time they are
14 treated somewhere in a central registry presumably in
15 Ottawa. Now, such registry exists in this province for
16 patients treated in this province but we feel it would be
17 a useful scheme on a national level.

18 COMMISSIONER FIRESTONE: Did you or your
19 associates put this request to the Dominion Bureau of
20 Statistics or to the Department of National Health and
21 Welfare?

22 DR. GUILD: This was done by the director
23 of Mental Health Services for the province, Dr. McLean,
24 I understand on many occasions.

25 COMMISSIONER FIRESTONE: Can you tell the
26 Commission if you know?

27 THE CHAIRMAN: To which, the Bureau or the
28 Department?

29 DR. GUILD: I am afraid I cannot give you
30 the answer but we would be glad to provide you with that



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1 information if you wish it. Do you know, Dr. Schrag?

2 DR. SCHRAG: I think it was to both and
3 the reply given was that the sanctity of private informa-
4 tion precluded such an organization.

5 COMMISSIONER FIRESTONE: I do not quite
6 follow this, what do you mean by sanctity of private
7 information? The Dominion Bureau of Statistics collects
8 a lot of statistics that concerns operations, the behaviour
9 of individuals and presumably it is similar to what this
10 particular statistical information would be.

11 DR. SCHRAG: If I understand you rightly,
12 when you get a mass of individual figures there is no real
13 identification and this I would agree with. However, there
14 are certain provinces who in submitting to the Dominion
15 Bureau of Statistics' cards on re-admissions refuse to put
16 the name of the individual. Some of these provincial
17 people rightly or wrongly feel that they should not divulge
18 anything about their patients which could be traced by
19 name.

20 COMMISSIONER FIRESTONE: I am trying to
21 understand the statistical requirement as it has been
22 outlined to us. Are you concerned about the name of the
23 patient or with the characteristics and the conditions and
24 the whole story of the patient's treatment?

25 DR. GUILD: So far as we are concerned the
26 patient could have a pseudonym so long as it was the same
27 in Ottawa and in the Province.

28 COMMISSIONER FIRESTONE: In other words,
29 that problem could be overcome easily and still give you
30 your required information?



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1 DR. GUILD: We hope so, we feel so.

2 COMMISSIONER FIRESTONE: Could you tell us
3 if there was any objection other than the name?

4 DR. SCHRAG: I believe not.

5 COMMISSIONER FIRESTONE: And since the name
6 is not essential this matter could be worked out, in your
7 opinion?

8 DR. SHCRAG: There would have to be some
9 means of identity.

10 COMMISSIONER FIRESTONE: Some method of
11 identifying without divulging a name?

12 DR. SCHRAG: Yes.

13 COMMISSION McCUTCHEON: Surely there comes
14 a time if it is to be of any use that you must have a
15 positive identification, you must be able to say that John
16 Brown is patient X, Y, Z?

17 DR. SCHRAG: There must be some way of
18 identifying these individuals.

19 THE CHAIRMAN: That is already in the hands
20 of the province, where he is a patient they know who
21 Patient X, Y, Z is.

22 DR. SCHRAG: But our population moves from
23 province to province and you may get a report from Quebec
24 that no name is a re-admission and from Ontario that no
25 name is a re-admission and if Alberta puts in a John Brown
26 you do not tie in the two others. That is the problem.

27 THE CHAIRMAN: It would appear there would
28 have to be disclosure?

29 COMMISSIONER FIRESTONE: Disclosure, if
30 you want to cover every case including those who move from one



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COMMISSIONER FIRESTONE: Disclosure, if

you want to cover every case including those who move from



1 province to another. However, if you are satisfied in
2 getting the information in relation to the people in the
3 province which you have a record of, you would not require
4 the name? We are trying to find what kind of form
5 would meet your requirements and get over the difficulties
6 you pose.

7 DR. GUILD: We have a registry in the
8 province.

9 COMMISSIONER McCUTCHEON: To which you have
10 access and you can get the private history?

11 DR. GUILD: Yes.

12 COMMISSIONER McCUTCHEON: So there is
13 disclosure. Any system that did not provide you with that
14 would not satisfy what you want to know?

15 DR. GUILD: That is right. We do, of course,
16 get requests all the time from patients who have moved
17 from other provinces and sought out new doctors and they
18 will write to us and request information and this is done
19 constantly. Whether this could be done on a universal
20 basis is a problem.

21 COMMISSIONER FIRESTONE: When you call for
22 these statistics are you thinking of terms of statistics
23 relating to the individual or aggregate figures?

24 DR. GUILD: Both, the experience in the
25 general population and the experience of a single individual
26 over a lifetime.

27 COMMISSIONER FIRESTONE: If you were unable
28 to get information on an individual because of this
29 difficulty we have just been discussing but you could
30 obtain the statistics would that meet your requirements?



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30 obtain the statistics would that meet your requirements?



1 DR. GUILD: Yes.

2 COMMISSIONER FIRESTONE: Would you be in
3 favour of such a survey which would only give you aggregate
4 figures rather than individual figures as well?

5 DR. GUILD: These figures are really
6 necessary in the interest of patients generally and for
7 the development and the contribution to research and for
8 training. Any survey, of course, would be welcome that
9 any way makes research better and more enlightening.

10 COMMISSIONER FIRESTONE: Not only welcome,
11 you would support such development you realize unless
12 somebody; a. I need statistics and b. I support such a
13 survey, the Royal Commission couldn't recommend it.

14 DR. GUILD: We would both subscribe to and
15 support it, sir.

16 THE CHAIRMAN: Dr. Guild, you would have mental
17 patients treated as all other patients?

18 DR. GUILD: Yes, sir.

19 THE CHAIRMAN: And paraphrasing what is
20 in your submission you would work towards the elimination
21 of the large units which you have now?

22 DR. GUILD: That is correct.

23 THE CHAIRMAN: What do you foresee as the
24 proper unit in the future?

25 DR. GUILD: There have been various estimates
26 of this, sir. They have varied from 150 beds to 500 beds.
27 I am sure you will encounter in British Columbia reports,
28 and elsewhere, reports produced under the leadership of
29 Dr. Pyhurst where they feel that the proper figure for
30 consideration is 400 patients. We would be open to a



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1 certain degree of flexibility on that figure in keeping
2 with various economical structural needs. This 400 regional
3 facility which we spoke of as 400 beds in round figures,
4 we would like to emphasize that it isn't just the 400 beds
5 that go into such a regional facility, that this regional
6 facility includes day and night hospital, children and
7 adolescent beds, includes guidance clinics, perhaps
8 forensic clinics, as much integrated psychiatric service
9 as possible.

10 THE CHAIRMAN: Do you see this unit as a
11 separate unit or possible general hospital?

12 DR. GUILD: Very much, sir, as part of a
13 general hospital under the same board, administered and
14 financed precisely the same way. I think the separation
15 of mental disorders from the rest of medicine has been
16 current too long.

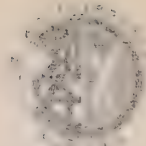
17 COMMISSIONER McCUTCHEON: What would happen
18 to your psychiatric nurse in that situation?

19 DR. GUILD: They work quite effectively in
20 psychiatric units of general hospitals at the moment.

21 COMMISSIONER McCUTCHEON: We were told that
22 they didn't, that they were only given the status of an
23 orderly and a much more lower rate of pay than the general
24 hospitals.

25 DR. GUILD: Perhaps I will refer to Dr.
26 Yonge.

27 DR. YONGE: I cannot answer with authority
28 about the reduced pay. Certainly in terms of capability
29 and acceptability there is no question in our own depart-
30 ment we are utilizing nurses that were trained in mental



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1 hospitals.

2 COMMISSIONER McCUTCHEON: Are they registered
3 nurses or so-called psychiatric nurses?

4 DR. YONGE: They are registered nurses.

5 COMMISSIONER McCUTCHEON: No.

6 DR. YONGE: I am not quite sure of my
7 ground here, but I think in Alberta all psychiatric trained
8 nurses are registered nurses.

9 THE CHAIRMAN: We heard to the contrary.

10 COMMISSIONER McCUTCHEON: You have a training
11 school run by the province for the training of psychiatric
12 nurses. They have a lower admission standard than would
13 be required for admission to become a registered nurse.
14 They are employed in mental hospitals. We were told they
15 weren't employed on the psychiatric wards of your general
16 hospitals except as orderlies, the rates of pay were down
17 to the orderly's rates of pay.

18 DR. YONGE: In our department at the
19 University Hospital we certainly use nurses who are R.N.,
20 registered nurses trained in a mental hospital.

21 COMMISSIONER McCUTCHEON: That was part of
22 the complaint of the psychiatric nurses this morning, that
23 the general hospitals insisted on registered nurses with
24 psychiatric training.

25 DR. GUILD: I think we would hope, sir,
26 a proper level of training could be arrived at by mutual
27 discussion. We are in the field of human behaviour and
28 human relations. We believe human relationships can be
29 resolved through negotiations and discussion. There is
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1 year trained nurse and the four-year trained nurse; if
2 I can put it that way and to include them and incorporate
3 them in a suitable way in the operation of the hospital.
4 The problem is rather quality of training and number of
5 personnel rather than mechanics of how this is to be done.

6 THE CHAIRMAN: Going to the matter that
7 Professor Firestone referred to in that Section 13 on
8 page 2 where you say that psychiatric services would best
9 be provided through a universally available pre-paid medical
10 insurance scheme. Do I understand you correctly that the
11 scheme that you endorse is a voluntary one?

12 DR. GUILD: Yes sir.

13 THE CHAIRMAN: Now, we are dealing with
14 emotionally disturbed people. Would the fact that the
15 individual is emotionally disturbed affect his judgment,
16 his deciding whether he would join a voluntary scheme?

17 DR. GUILD: We are dealing with the general
18 population.

19 THE CHAIRMAN: We are dealing with the
20 individual as part of that population, are we not?

21 DR. GUILD: Yes, but we would presume that
22 the majority of people are not ill continually, that they
23 are ill perhaps part of the time, and then they are well.
24 If it covers the majority of the population, then we feel
25 that the people presumably would take out such a pre-paid
26 scheme when they have their best judgment about them. If
27 they are sick at this particular time, presumably we would
28 not deny them treatment. I am not quite sure of the
29 mechanics of how this might work. It is an interesting
30 point.



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1 THE CHAIRMAN: I would like to refer to
2 the head of the family in relation to the rest of the
3 family who wouldn't be emotionally disturbed, not necessarily
4 be emotionally disturbed.

5 DR. GUILD: I am not clear whether you
6 are raising a legal point about validity.

7 THE CHAIRMAN: No, I am not. I am raising
8 what must be a human situation arising in the day to day
9 operations of a voluntary scheme.

10 DR. GUILD: Perhaps I feel fewer people
11 would have their capacity for judgment impaired sufficiently
12 that they wouldn't be able to make this kind of appraisal
13 as might be popularly believed except for these people who
14 are very sick now with the major psychosis in which
15 judgment is disturbed. We feel people in the categories of
16 neurosis are characterized by the fact they do have some
17 adjustment to reality. This would allow them to make the
18 necessary decision.

19 THE CHAIRMAN: Those that were disturbed
20 the most would be those who would need protection the
21 most?

22 DR. GUILD: Yes. That would presumably
23 include those who were in hospital at the moment of the
24 inception of this scheme. I think this is something to
25 which we should address our attention. I cannot give you
26 a definitive answer at the moment.

27 THE CHAIRMAN: Can you give any approxima-
28 tion in figures, in terms of your population, the terms
29 of the emotionally disturbed population that might come into
30 the category we are talking about at the moment?

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1 DR. SCHRAG: I don't quite understand your
2 question, the same individual that would deny his family
3 medical insurance?

4 THE CHAIRMAN: Assume that to be the fact.

5 DR. SCHRAG: I think there may be occasions
6 here just as we have with parents who deny their children
7 medical care under the present medical programme. There
8 may have to be legal methods by which these individuals
9 do receive care. Now those in the ordinary welfare situation
10 can be enforced and the costs legally collected. I think
11 that possibly some mechanism of this sort may have to be
12 introduced by welfare legislation to care for these
13 individuals.

14 THE CHAIRMAN: In the free operation of
15 the free economy as we have heard where do you draw the
16 line as to who is going to say whether I should be required
17 to take out coverage or not?

18 DR. SCHRAG: I think that would be the
19 situation now, sir, if this individual falls ill and has
20 no coverage and has an estate a person has the right to
21 sue for collection. If he has no estate then it is
22 handled through welfare.

23 DR. GUILD: Presumably too the family
24 would have something to say in such a situation and their
25 wishes would be taken into consideration.

26 THE CHAIRMAN: How would that be translated
27 into action? How do you see it translated into action?

28 DR. GUILD: If a man is in hospital with
29 a major psychosis surely it wouldn't be beyond the wife
30 to take out the insurance for that family. You are speaking



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1 here of the financial burdens of it?

2 THE CHAIRMAN: I am speaking of the judgment
3 problem.

4 DR. GUILD: We would assume the wife, if
5 she was well, would be able to judge.

6 THE CHAIRMAN: You don't see it as a problem?

7 DR. GUILD: We didn't consider it as a
8 problem up to now. We shall certainly give it some
9 consideration. Dr. Yonge perhaps would like to speak to
10 it.

11 DR. YONGE: May I suggest that the real
12 issue here about impaired judgment rejecting medical care,
13 I think what Dr. Guild intimated really refers to cases
14 of the illness and it seems to me that it is more likely
15 that an individual who periodically may have his judgment
16 impaired so that he doesn't like doctors and won't go to
17 them, that this individual is more likely to get his care
18 if he has a pre-paid plan utilizing these areas in his
19 experience when his judgment is not impaired. I think
20 the objection of the impairment of judgment is an objection
21 against medical care or the sense of needing of it rather
22 than an objection to embarking in life-long medical care
23 insurance.

24 THE CHAIRMAN: Thank you, gentlemen. You
25 have been very helpful. As you know we are making these
26 additional studies in this problem of psychiatric care,
27 mental disorders and so forth as one of our major areas
28 of study.

29 DR. GUILD: We would like to thank the
30 Commission for the opportunity of appearing before you and



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the objection of the impairment of judgment is an objection

against medical care or the sense of needing it rather

than an objection to embarking in long-range medical care

insurance.

have been very helpful. As you know we are making these

additional studies in this problem of psychiatric care.

mental disorders and so forth as one of our major areas

of study.

DR. GUILD: We would like to thank the

Commission for the opportunity of appearing before you and



1 presenting this brief. I would like to take this opportunity
2 as well, as a psychiatrist, to hope and wish that your
3 labours will not be too stressing and you will not be too
4 taxed.

5 THE CHAIRMAN: The next submission is that
6 of the Calgary Pure Water Association.

7 Is there anyone here on behalf of the
8 Calgary Pure Water Association either to present a brief
9 or to speak to the subject regarding which we were notified
10 that somebody would be here. Have you had any word, Mr.
11 Lafrance?

12 THE SECRETARY: No, sir.

13 THE CHAIRMAN: The next brief is the
14 Edmonton Fluoridation Council.

15 THE SECRETARY: That will be Exhibit 134.

17 ---EXHIBIT NO. 134: Brief of the Edmonton
18 Fluoridation Council

19 SUBMISSION OF

20 EDMONTON FLUORIDATION COUNCIL

21 APPEARANCES:

22 Dr. C. R. Castaldi

23 Dr. G. Clarke

24 Mr. W. F. Macallister

25
26 DR. CASTALDI: Mr. Chairman and Honourable
27 Members of the Royal Commission, it gives me great pleasure
28 to present on behalf of the Edmonton Fluoridation Council
29 a brief on the subject of fluoridation. I am Professor of
30 Children's Dentistry at the University of Alberta and assume



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Lawrence?

THE SECRETARY: No, sir.

THE CHAIRMAN: The next brief is the

Edmonton Filtration Council.

THE SECRETARY: That will be Exhibit 134.

---EXHIBIT NO. 134: Brief of the Edmonton

EDMONTON FILTRATION COUNCIL

Dr. G. Clarke

Mr. W. E. MacCallister

DR. CASTALDI: Mr. Chairman and Honourable

Members of the Royal Commission, it gives me great pleasure
to present on behalf of the Edmonton Filtration Council
a brief on the subject of Filtration. I am Professor of
Childron's Dentistry at the University of Alberta and assume



1 a full time teaching capacity. I do spend a small amount
2 of my time in private practice taking care of things such
3 as needy children, mentally retarded, distrophy, cleft
4 lip and cleft palate. I would like to introduce Dr.
5 George Clarke, who is a member of the Alberta Dental
6 Association of Practising Dentists and who is our secretary-
7 treasurer and Mr. Fraser Macallister who is a businessman.

8 Mr. Chairman, when it was announced that
9 the Royal Commission was going to be set up on the subject
10 of national health insurance or the possibility of it,
11 it was the feeling of my Council that we would plan on
12 presenting a brief. We were concerned in considering the
13 question of national health insurance and as we felt the
14 millions of dollars of the taxpayers' money that would be
15 involved in terms of experience in England with regard to
16 dental health scheme that has been going on a considerable
17 period of time, the information that we have is that dental
18 conditions are not improving under the national health
19 scheme. We feel this is because every available preventive
20 measure has not been put into effect. I would like at
21 this time to read the summary and recommendations of our
22 brief.

23 SUMMARY AND RECOMMENDATIONS

24 Summary:

25 In this brief the financial, the sociologi-
26 cal, the political and public health aspects of fluorida-
27 tion and dental health in Canada have been reviewed and the
28 following conclusions reached.

- 29 1. The most widespread unmet health need in Canadian
30



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measure has not been put into effect. I would like at
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brief.

SUMMARY AND RECOMMENDATIONS

In this brief the financial, the sociologi-
cal, the political and public health aspects of the situa-
tion and dental health in Canada have been reviewed and the
following conclusions reached.

1. The most widespread unmet health need in Canadian



1 children is in the field of oral health.

2 These are the figure presented at the
3 Canadian Dental Association meeting in 1960 where it was
4 my pleasure to attend.

5 2. The estimated cost of meeting this health need by
6 treatment methods in children alone would repre-
7 sent the total outlay for dental expenses by all
8 Canadians in 1960 or a figure closely approximating
9 it.

10 3. Dental disease is a mass disease and requires mass
11 methods of prevention. Fluoride administration on
12 an individual basis is an inferior preventative
13 to fluoridation.

14 4. Children from low socio-economic families are
15 underprivileged as far as dental health is
16 concerned.

17 5. Although the actual nature of dental disease does
18 not vary from province to province there is
19 extreme variation in provincial laws governing
20 the most effective method of prevention:
21 fluoridation. In New Brunswick fluoridation is
22 not possible under existing public health laws:
23 in Saskatchewan municipal council can enact fluorida-
24 tion, while, in Alberta a plebiscite requiring a
25 66 2/3% majority vote is necessary.

26 We recognize, sir, these are under the responsibility of
27 provincial laws and the national organization, a national
28 commission cannot do much about it. Nevertheless we feel
29 that this should be brought to the attention at the
30 national level.



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65 2/3 majority vote is necessary.

We recognize, sir, there are under the responsibility of

provincial laws and the national organization, a national

commission cannot do much about it. Nevertheless we feel

20 that this should be brought to the attention of the



6. Analysis of voting behaviour in three fluoridation plebiscites in Edmonton indicates that where the need for fluoridation is greatest (low socio-economic areas) voters in this area lack knowledge about fluoridation.

THE CHAIRMAN: You mean they vote against it?

DR. CASTALDI: They tend to.

In these areas they turn out to vote in smaller numbers and vote against fluoridation.

7. Despite the fact that Canada has one of the world's most carefully conducted and longest running fluoridation studies, which has provided annual reports attesting to the safety and beneficial effects of fluoridation, there is a marked lag in the institution of fluoridation across Canada.

In Canada, approximately one person in eighteen is getting the benefits of water fluoridation. In the U.S.A. it is approximately one in five. That is based on studies in Canada. The Legislature of Ireland has recommended national fluoridation.

8. Although a public health grant for the control of cancer has been established through dominion-provincial public health grant arrangements, no such grant exists for the control of dental care through fluoridation. Yet, fluoridation is a proven preventative for dental caries, the cheapest and most effective available, while the control of cancer is presently based on treatment



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characterized in Edmonton indicates that where the

need for fluoridation is greatest (low socio-

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1 methods alone.

2 9. The cost of dental treatment (fillings and extrac-
3 tions only) in comparable groups of Grade 4
4 children in Camrose, Alberta (low fluoride) has
5 been estimated at \$1568.00, while in Wetaskiwin,
6 Alberta (1.0 - 1.5 p.p.m. fluoride), the cost was
7 \$708.00.

8 If one would assume, sir, that the cost of living -- other
9 aspects of the cost of living are equal, then one could
10 safely say that a cost of living in a non-fluoride
11 community or in an inadequate fluoride community is
12 actually higher.

13 10. Canadian are more likely to suffer loss of liberty
14 from the financial burden of the rising cost of
15 welfare dental service than they are from having
16 to use fluoridated water.

17 11. The courts have never ruled that fluoridation
18 violates civil liberty.

19 Recommendations:

20
21 1. That in order to insure maximum conservation of
22 Canada's economic resources, the initial use of
23 taxpayers' money for the improvement of dental
24 health should be used where it will have maximum
25 benefit, namely in the field of prevention, through
26 (in order of importance)

27 (a) fluoridation where community water systems
28 exist,

29 (b) individual fluoride administration where
30 no community water systems exist,



The cost of dental treatment (fillings and extractions only) in comparable groups of Grade 4

children in Ontario, Alberta (low fluoride) has been estimated at \$158.00, while in Saskatchewan, Alberta (1.0 - 1.5 p.p.m. fluoride), the cost was \$708.00.

If one would assume, first, that the cost of living -- other aspects of the cost of living are equal, then one could safely say that a cost of living in a non-fluoride community or in an inadequate fluoride community is actually higher.

Canadian are more likely to suffer from or liberty from the financial burden of the rising cost of welfare dental service than they are from having to use fluoridized water.

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That in order to insure maximum conservation of Canada's economic resources, the rational use of taxpayers' money for the improvement of dental health should be used where it will have maximum benefit, namely in the field of prevention, through (in order of importance)

(b) individual fluoride administration where no community water systems exist,



1 (c) public health education about fluoridation.

2 2. That no government sponsored prepaid program for
3 dental services be instituted until every possible
4 method of prevention has been put into effect.

5 3. That the Minister of National Health and Welfare
6 provide the necessary leadership toward the in-
7 stitution of national fluoridation by calling
8 together provincial ministers of health for a
9 conference on the subject of fluoridation for
10 Canada.

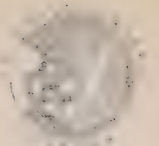
11 I learned yesterday that this may not be possible. On the
12 other hand, there does exist an Edmonton Health Council
13 which consists of the Minister of Health at the national
14 level and the Deputy Minister, so it might be partially
15 possible.

16 4. That the Minister of National Health and Welfare
17 and Provincial Ministers of Health discharge their
18 responsibilities to the public by making official
19 public statements about the safety, effectiveness
20 and low cost of fluoridation.

21 5. That a public health grant for the purchase of
22 fluoridation equipment be established under existing
23 dominion-provincial health grant arrangements.

24 Well, sir, since the possibility might
25 exist among members of the Commission that we are here
26 merely to complain, I would like to point out that we have
27 done extensive work in an attempt to educate the public,
28 and I would like our secretary, Dr. Clarke, to read what
29 our activities have been, sir.

30 DR. CLARKE: Mr. Chairman, the number of



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23 legislation.

24 Well, sir, since the possibility might

25 exist among members of the Commission that we are here

26 merely to complain, I would like to point out that we have

27 done extensive work in an attempt to educate the public,

28 and I would like our secretary, Dr. Clarke, to read what

29 our activities have been, sir.

30 DR. CLARKE: Mr. Chairman, the number of



1 lectures presented to Home and School Associations, 51.
2 I might point out that we were always invited to present
3 these lectures. The number of lectures to service clubs,
4 Y.W.C.A., and other similar groups, 25. The number of
5 radio talks, three. The number of T.V. presentations,
6 four. Those numbers are low because they cost us quite
7 a lot of money, and we found our campaign suffered from
8 shortage of funds. Numbers of papers published in scientific
9 journals, three. Fundamental research programmes taken,
10 three. Number of master's theses taken, one. Letters
11 to the editors of newspapers, approximately 45.

12 We have distributed thousands of pamphlets,
13 and we have examples of the type distributed in this book,
14 which we will give to you as exhibit A of the Edmonton
15 Fluoridation Council.

16 We have received requests for these pamphlets
17 from government supported public health clinics, because
18 very few have been available from government sources in
19 Alberta, and we regret that we have to say this, sir, but
20 it was a burden on us, and we find it important to mention.

21 We have on two occasions written to
22 practically every member of the legislative assembly of
23 Alberta, and we have made a personal appeal to the Premier
24 of Alberta in relation to the matter of changing the law,
25 and we have written to Members of Parliament in Ottawa,
26 including the Minister of Health and Welfare.

27 THE CHAIRMAN: And in what period has this
28 been done?

29 DR. CLARKE: This is the period of time
30 in which plebiscites have been held in the city of Edmonton.



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shortage of funds. Numbers of papers published in scientific

to the editors of newspapers, approximately 75.

We have distributed thousands of pamphlets,

and we have examples of the type distributed in this book,

which we will give to you as exhibit A of the Edmonton

We have received requests for these pamphlets

from Government departments, the Royal Canadian Mounted

very few have been available from Government sources in

Alberta, and we regret that we have to say this, sir, but

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We have on two occasions written to

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of Alberta in relation to the matter of changing the law,

and we have written to Members of Parliament in Ottawa,

including the Minister of Health and Welfare.

THE CHAIRMAN: And in what period has this

R. CLARK: This is the period of time

in which plebiscites have been held in the city of Edmonton.



1 THE CHAIRMAN: From what year to what year?

2 DR. CLARKE: It will run from the first one,
3 which was in 1957, 1959, and 1961, sir. Those three.

4 THE CHAIRMAN: What is your situation now?
5 Do you regard yourselves as being stymied?

6 DR. CLARKE: No, sir.

7 THE CHAIRMAN: Where do you go from here?
8 Or, where do you plan to go from here?

9 DR. CLARKE: We find it encouraging, sir,
10 that the public is becoming more fully acquainted with this
11 matter. We realized at the outset that it was a difficult
12 matter for them to understand it. It involves chemistry,
13 and not very many of us are well acquainted with the
14 chemistry to understand it. But because there have been
15 Royal Commissions in New Zealand, which studied it from
16 1955 to 1957, and studies it exhaustively, and issued a
17 report favourable to it, and a Royal Commission which was
18 a committee of the Alberta Research Council in our own
19 province from 1952 to 1954 who published a report in favour
20 of it, and the latest one in Canada, the one in Ontario,
21 from 1959 to 1961. These have all helped spread informa-
22 tion about it, and we find in our own city here that the
23 interest has increased, and people talk about it more and
24 are learning more about it, and definitely the parents
25 of young children are very much in favour of it. They want
26 to get it.

27 We are going to keep fighting for it, sir.

28 THE CHAIRMAN: The reason being that the
29 dental profession believes that it is in the public
30 interest?



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DR. CHAMBERLAIN: It will run from the first one which was in 1957, 1959, and 1961, sir. Those three.

Do you regard yourselves as being stymied?

THE CHAIRMAN: Where do you go from here?

Or, where do you plan to go from here?

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We are going to keep fighting for it, sir.

THE CHAIRMAN: The reason being that the dental profession believes that it is in the public interest?



1 DR. CLARKE: Right.

2 COMMISSIONER STRACHAN: I do not think,
3 Mr. Chairman, that any questions of mine could elicit more
4 information than has already been given in this brief,
5 but I would trust that if any of the representatives of
6 this group have anything to add, they will do so at this
7 time.

8 DR. CASTALDI: Sir, our exhibit here con-
9 tains actual information which may be of value to the
10 Commission. It includes examples of our educational
11 activities, our pamphlets, research papers published are
12 included in here. We included copies of letters to public
13 officials. We have rather interesting examples of anti-
14 fluoridation literature being circulated. We have examples
15 of letters to newspaper editors.

16 THE CHAIRMAN: Dr. Castaldi, are you filing
17 that book as an exhibit?

18 DR. CASTALDI: Yes, and we also have a
19 copy of the Master's thesis called "Some Sociological
20 Aspects of a Fluoridation Plebiscite".

21
22 ---EXHIBIT NO. 134A: Information on Activities
23 of the Edmonton Fluoridation
24 Council.

25 ---EXHIBIT NO. 134B: "Some Sociological Aspects
26 of a Fluoridation Plebiscite"
27 a thesis submitted to the
28 Faculty of Graduate Studies
29 in Partial Fulfilment of
30 the Requirements for the
Degree of Master of Arts,
by David Gomer Fish.

COMMISSIONER BALTZAN: Gentlemen, I commend you



Mr. Chairman, that any questions of mine could elicit more information than has already been given in this brief, but I would trust that if any of the representatives of this group have anything to add, they will do so at this time.

DR. GASTALDI: Sir, our exhibit here con-

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Information on Activities

---EXHIBIT NO. 134A:

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a thesis submitted to the
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1 on your crusade, and I notice here for the first time that
2 there is a fluoridation council. It has not come to my
3 attention before.

4 I have no very important questions, just
5 this one thing. Has the value of this fluoride toothpaste
6 been proven yet?

7 DR. CASTALDI: Well, certainly there is
8 one dentifrice now which has received some favourable
9 comment by the organized dentistry, and I believe it has
10 been given what is called a B-rating, which means that
11 the research is quite acceptable for the moment, but some
12 more must be done, and I believe this is the first in a
13 series of therapeutic dentifrices. I think the picture
14 is definitely changing. However, we still have considerable
15 difficulty in the development.

16 COMMISSIONER BALTZAN: Thank you.

17 COMMISSIONER FIRESTONE: Dr. Clarke, did
18 I understand that your Council has written to the Minister
19 of National Health and Welfare in Ottawa in connection with
20 fluoridation?

21 DR. CLARKE: Yes, sir.

22 COMMISSIONER FIRESTONE: What reply did you
23 receive?

24 DR. CLARKE: It is in the exhibit.

25 DR. CASTALDI: The statement was this, as
26 far as the present constitutional arrangements are con-
27 cerned with regard to health matters, there is very little
28 that the Federal Government could do. However, he did
29 point out that -- and this was rather surprising to me --
30 that the Federal Government, through their correspondence



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COMMISSIONER FURSTON: Dr. Clarke, did

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that the Federal Government could do. However, he did

point out that -- and this was rather surprising to me --

that the Federal Government, through their correspondence



1 and relationships with the Provincial Ministers attempt
2 to give the people what they ask for. This is what he
3 said.

4 And he said, "We would like to point out
5 that they have not asked for this; if they would ask for
6 such a public health grant, they certainly would take it
7 into very serious consideration."

8 COMMISSIONER FIRESTONE: Have your Council
9 asked the Provincial Government of Alberta to ask the
10 Federal Government to give a health grant to the province
11 so they, in turn, can pass it on to those municipalities
12 that wish to acquire fluoridation equipment for the
13 purpose of fluoridating water?

14 DR. CASTALDI: I have made this suggestion
15 to the Department of Health, yes. In fact, we attempted
16 to have one of the committees that passed water fluorida-
17 tion in Alberta request that funds be made available to the
18 Maternal and Child Welfare Grant, and they did not seem
19 to take it up. It was a test case.

20 COMMISSIONER FIRESTONE: Has your Council
21 made a specific request to the Minister of Health in the
22 Province of Alberta for such a health grant?

23 DR. CASTALDI: No, sir. We have not, in
24 writing.

25 COMMISSIONER FIRESTONE: I see.

26 Would you feel that in the light of the
27 information that was passed on to you by the Federal Minister
28 of National Health and Welfare that this would be the
29 proper procedure?

30 DR. CASTALDI: Yes, sir.



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8 COMMISSIONER WIRSTONE: Have your Council

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15 to the Department of Health, yes. In fact, we attempted

16 to have one of the committees that passed water fluorida-

17 tion in Alberta request that funds be made available to the

18 Government of Alberta to do this.

19 to take it up. It was a test case.

20 I am sure that the Government of Alberta will

21 make a specific request to the Minister of Health in the

22 Province of Alberta for such a health grant.

23 DR. CASTALDI: No, sir. We have not, in

24 COMMISSIONER WIRSTONE: I see.

25 Would you feel that in the light of the

26 information that was passed on to you by the Federal Minister

27 of National Health and Welfare that this would be the

28 DR. CASTALDI: Yes, sir.



1 COMMISSIONER FIRESTONE: And, assuming that
2 you agree that this is the proper procedure, and I under-
3 stand from your reply you do, would your next step not
4 be to make it?

5 DR. CASTALDI: Yes, we do agree.

6 COMMISSIONER FIRESTONE: And are you planning
7 to make such a request?

8 DR. CASTALDI: Yes, we are, sir.

9 COMMISSIONER FIRESTONE: If you were to do
10 so, did you have any specific amount in mind? Did you have
11 in mind a federal-provincial matching grant, or what did
12 you have specifically in mind when you put this recommenda-
13 tion to us, which is:

14 "That a public health grant for the purchase
15 "of fluoridation equipment be established
16 "under existing dominion-provincial health
17 "grant arrangements"?

18 DR. CASTALDI: Yes. This was a question which
19 we raised in our own mind, where was the money to come
20 from.

21 COMMISSIONER FIRESTONE: And how much.

22 DR. CASTALDI: Yes. We got very great
23 assistance from the report presented by the Government on
24 Monday, because on page 29 there is a list of amount of
25 grants available, and how much was picked up, and we learned
26 some interesting things. For instance, under the Maternal
27 and Child Welfare Grant, which is not a matching grant,
28 the approximately \$50,000.00 was not picked up in 1960.

29 Now, this, as far as we were concerned, would
30 be a very good source of money.



COMMISSIONER FIRESTONE: And, assuming that

You agree that this is the proper procedure, and I under-

stand from your reply you do, would your next step not

be to make it?

DR. CASTALDI: Yes, we do agree.

COMMISSIONER FIRESTONE: And are you planning

to make such a request?

DR. CASTALDI: Yes, we are, sir.

COMMISSIONER FIRESTONE: If you were to do

so, did you have any specific amount in mind? Did you have

in mind a federal-provincial matching grant, or what did

you have specifically in mind when you put this recommenda-

tion to us, which is:

"That a public health grant for the purchase

"of fluoridation equipment be established

"under existing Dominion-provincial health

agreements."

DR. CASTALDI: Yes. This was a question which

we raised in our own mind, where was the money to come

from.

COMMISSIONER FIRESTONE: And how much.

DR. CASTALDI: Yes. We got very great

assistance from the report presented by the Government on

Monday, because on page 29 there is a list of amount of

grants available, and how much was picked up, and we learned

some interesting things. For instance, under the Maternal

and Child Welfare Grant, which is not a matching grant,

the approximately \$50,000.00 was not picked up in 1960.

Now, this, as far as we were concerned, would

be a very good source of money.



1 For example, on the basis of approximately,
2 let us say, \$3,000.00, which may be a very high figure for
3 fluoridation equipment for the average community, or let
4 us in fact talk about the terms of the population. Such
5 an amount of money, if we took one-fifth of it, \$10,000.00,
6 we could fluoridate half of Alberta by means of Edmonton
7 and Calgary.

8 There appears to be money there. The
9 question is to go after it.

10 COMMISSIONER FIRESTONE: This \$10,000.00
11 figure you are talking about is a capital grant. It is
12 made one time; is that it?

13 DR. CASTALDI: Yes.

14 COMMISSIONER FIRESTONE: For equipment?

15 DR. CASTALDI: Oh, yes, this would be the
16 once, yes. I am merely speaking about the Maternal and
17 Child Welfare Grants at the present time.

18 COMMISSIONER FIRESTONE: Can we relate the
19 question back again to your recommendation under five.
20 What we are trying to find out is what kind of grant did
21 you have in mind; what amount and whether it should be
22 federal-provincial matching grants?

23 I may be of help to you further, if you had
24 not considered this matter, it would be quite all right to
25 consider it some other time and let us have your answer
26 in writing subsequently.

27 DR. CASTALDI: We have considered it, although
28 we have not come to a final conclusion. It appeared to
29 us that it might be very sensible to point out that under
30 the terms of this grant that fluoridation equipment should



For example, on the basis of approximately,

let us say, \$8,000.00, which may be a very high figure for

fluoridation equipment for the average community, or let

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is a small amount of money, and it is a small amount of money.

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figure you are talking about is a capital grant. It is

made one time; is that it?

DR. CASTAÑEDA: Yes.

COMMISSIONER FRIESTON: Yes.

DR. CASTAÑEDA: Oh, yes, this would be the

once, yes. I am merely speaking about the material and

the other side of the coin is the human side.

COMMISSIONER FRIESTON: Can we relate the

material side to the human side?

DR. CASTAÑEDA: Yes, it is a very simple matter.

For example, if we take the case of the city of

Calgary, we can see that the material side is

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not considered this matter, it would be quite all right to

consider it some other time and let us have your answer

COMMISSIONER FRIESTON: Yes.

DR. CASTAÑEDA: We have considered it, although

we have not come to a final conclusion. It appeared to

us that it might be very sensible to point out that under

the terms of this grant that fluoridation equipment should



1 be included as one of the conditions since Alberta happens
2 to be one of the provinces which picks up a higher per-
3 centage of these grants than other provinces. We are
4 presently only picking up 50% or 60% of this grant. It
5 would appear to us reasonable that fluoridation equipment
6 could be included within the terms of this grant under
7 the conditions set up by the Federal Government.

8 COMMISSIONER FIRESTONE: You appreciate
9 that we, as a Royal Commission, have to advise the
10 Federal Government?

11 DR. CASTALDI: Yes.

12 COMMISSIONER FIRESTONE: And if we get
13 suggestions from groups like yourself that the grant should
14 be made, we ought to know what kind of grant and how much
15 is involved on a per capita basis. We need some specific
16 things rather than some general conditions. General
17 conditions are very helpful, but if they can be substantiated
18 it would help us a little more to come to grips with the
19 problem. Unless we get them from the people knowledgeable
20 in the field, it would perhaps be somewhat more difficult.

21 DR. CASTALDI: We would be happy to put it
22 in writing and send it to the committee.

23 DR. CLARKE: May I speak to that subject,
24 Mr. Chairman.

25 THE CHAIRMAN: Yes.

26 DR. CLARKE: Yesterday I checked and found
27 in the Province of Alberta there are 195 water works
28 systems and they supply piped water to 65.7% of the popula-
29 tion. I think that the Province is remarkably well favoured
30 in that respect, in that it is easy to provide fluoridation



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in that respect, in that it is easy to provide this



1 to water systems. It is economical; it is safe, and our
2 point was that if we could get some encouragement to
3 these communities by means of a grant to enable them to
4 see that their cost of instituting fluoridation would not
5 be a great amount, then it would further the cause.

6 It is easy to calculate, for example, 200
7 systems. We know that many of them are small and that
8 the cost for the equipment is approximately \$3,000.00.
9 You multiply the 200 by the \$3,000.00 and you \$600,000.00
10 which would put the equipment in. The cost of the actual
11 chemical is very low.

12 So that this is the major cost. And, as
13 you pointed out, sir, it is just once. It would last for
14 20 years or more. In fact, I notice that the Province of
15 Alberta spends almost a quarter of a million dollars in
16 dental expenses for welfare recipients and others, and
17 almost a quarter of a million dollars in the public health
18 units, and that this amount of money in terms of those
19 others is quite small. And encouragement by a federal
20 body to promote this sort of thing would be an advantage
21 to the people of the Province of Alberta.

22 COMMISSIONER FIRESTONE: This is a very
23 helpful elaboration of the answer which we have already
24 received, and we would certainly welcome a specific pro-
25 posal at a later date, if that is convenient to you.

26 May I ask one or two related questions.

27 I understand that you tried in the City of
28 Edmonton twice to obtain fluoridation?

29 DR. CASTALDI: Three times.

30 COMMISSIONER FIRESTONE: Yes, and the vote



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3 these communities by means of a grant to enable them to
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1 was unfavourable in all three instances?

2 DR. CASTALDI: It was not really unfavourable.

3 We got on these three particular times -- 54% of the public
4 in favour the first time; 57% the second; and 62, the
5 third time. And yet under the terms of our law we still
6 do not have water fluoridation. The majority favour it,
7 but this is the situation.

8 COMMISSIONER FIRESTONE: It was favourable
9 in the sense of majority in all three cases, but not
10 favourable enough to get this scheme adopted. What were
11 the objections raised by those who objected to fluorida-
12 tion?

13 DR. CLARKE: They fall into three categories,
14 generally. They attack it first on the basis of poison.
15 They tried to induce fears and doubts into the minds of
16 a great many people. It is then attacked on the basis that
17 it just doesn't work as they claim it works, and therefore
18 it is a waste of the taxpayer's money. It is finally
19 attacked on the grounds that it is a violation of the
20 rights, the civil rights of the people.

21 These, briefly, are the bases on which it
22 is attacked.

23 COMMISSIONER FIRESTONE: I presume you have
24 convinced those people, as your answers indicate, that it
25 was not really poison?

26 DR. CLARKE: I am sure we did.

27 DR. CASTALDI: Those who voted, we did, we
28 thought, fairly well.

29 COMMISSIONER FIRESTONE: I see. Well now,
30 sir, since you have tried three times, over what period of



1 was unanswerable in all three instances?

2 DR. CASTLE: It was not really unanswerable.

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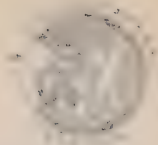
2 DR. CASTALDI: Well, four years. According
3 to the law, the vote comes up every two years, but taking
4 1957, 1959, it is three times.

5 COMMISSIONER FIRESTONE: Assuming that it
6 may take you another given period, two years, four years
7 or longer, I am just wondering whether an interim arrange-
8 ment could not be worked out by using individual fluoride
9 administration to help those that want the help? There
10 must be many families with children that are concerned
11 about the dental health requirements of the child? Why
12 could they not in an interim have a scheme of individual
13 fluoride to be developed to give them a chance to partici-
14 pate in this scheme?

15 DR. CASTALDI: This has been suggested and
16 has been done quite often by the dentist. When I go to the
17 Home and School meetings I have a pocket of prescriptions
18 to give to people when they ask for them to use it. The
19 Department of Health in the City of Edmonton has the matter
20 under advisement and they are about to present their
21 thinking to the City of Edmonton on this matter.

22 COMMISSIONER FIRESTONE: Have you yourself
23 a proposal of what can be done on an interim basis until
24 you can succeed in getting an ideal solution?

25 DR. CASTALDI: Well, I believe that we
26 should encourage people to take fluoride pills if they
27 want them and if they have the money to buy them and if the
28 Health Department is willing to sponsor it. Unfortunately,
29 the cost is rather high and with a limited number of dollars
30 they feel the money could go where it will do the most good.



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3 to the law, the vote comes up every two years, but taking
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26 should encourage people to take fluoride pills if they
27 want them and if they have the money to pay them and if the
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1 COMMISSIONER FIRESTONE: What would be the
2 cost of providing these pills for a family of four for a
3 year?

4 DR. CASTALDI: Again we get into the cost
5 of drugs. As was pointed out the other day it may vary
6 depending on where the drugs come from and who prepares
7 them. It appears under the present circumstances the cost,
8 there is about as much of a cost in dispensing them and
9 getting them into bottles as the cost of the tablets. We
10 have received estimates of the cost and they varied all the
11 way from about one cent a tablet, that is to say wholesale
12 from one company to, I think, twenty cents a hundred or
13 something like that.

14 COMMISSIONER FIRESTONE: One cent a tablet
15 to two and a half cents?

16 DR. CASTALDI: This was the wholesale cost
17 that we were quoted.

18 COMMISSIONER FIRESTONE: From one cent to
19 two and a half cents a tablet?

20 DR. CASTALDI: Somewhere in this area
21 although I would suspect that when large quantities would
22 be purchased it probably would be cheaper.

23 COMMISSIONER FIRESTONE: How many tablets
24 would be required for a family of four for a year?

25 DR. CASTALDI: One every day, 365 days a
26 year, 1,440 tablets.

27 COMMISSIONER FIRESTONE: In other words,
28 about \$14.00 or \$15.00 a year?

29 DR. CASTALDI: I believe that is what it
30 presently costs the people who are doing this in the city.



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1 COMMISSIONER STRACHAN: Are they considered
2 as effective as communal fluoridation of the water supply?

3 DR. CASTALDI: The one study that has been
4 reported, and this was just recently, indicated that the
5 effects may be better with studies that were published back
6 in 1947 with regard to water fluoridation or fluoride
7 studies in the United States. Now, I think it is unfor-
8 tunate the studies were set up in such a way that they did not
9 create an adequate control. They set it up with a group
10 of people who would be most likely to follow through
11 and they were mostly physicians, dentists and biologists
12 in the Institute of Health in the United States. After
13 eight years only half the people who participated in the
14 study could be used to evaluate because the other half
15 had quit taking the pills.

16 COMMISSIONER STRACHAN: You were dealing
17 with adults?

18 DR. CASTALDI: That is right, they were
19 given pills for nothing and they were mostly physicians
20 and dentists and they were given to their children.

21 COMMISSIONER McCUTCHEON: They were not
22 taking them themselves?

23 DR. CASTALDI: No.

24 COMMISSIONER FIRESTONE: To bring this to a
25 conclusion, could you tell us whether dentists in Edmonton
26 when they see their patients recommend that they should
27 use these individual fluoride pills or at least give them
28 to their children?

29 DR. CASTALDI: I believe the majority of
30 them do but there are some, I believe, who are concerned

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them do but there are some, I believe, who are concerned



1 about the fact that these pills may be in the home and
2 there is always a danger of children getting more than
3 they should. That is one of the great advantages of the
4 communal water control.

5 DR. CASTALDI: You arrived at a figure of
6 approximately \$15.00, do you recall?

7 COMMISSIONER FIRESTONE: Yes.

8 DR. CASTALDI: Do not forget that is a
9 wholesale price. I would not want anyone in this room to
10 think they could get these pills for a family of four for
11 \$15.00 in the City of Edmonton.

12 COMMISSIONER FIRESTONE: What would they
13 have to pay?

14 DR. CASTALDI: I would think the distribu-
15 tion cost and so on would at least double that amount. I
16 am not familiar with the actual cost.

17 THE CHAIRMAN: Are they obtained by pres-
18 cription or may they be purchased without prescription?

19 DR. CASTALDI: They may be purchased without
20 prescription.

21 COMMISSIONER FIRESTONE: And the cost might
22 be doubled?

23 DR. CASTALDI: They are prescription.

24 THE CHAIRMAN: Would you gentlemen agree?

25 DR. CASTALDI: I was not aware they were
26 available without prescription. I know when one writes a
27 prescription one can pick up the second lot without a
28 prescription.

29 COMMISSIONER McCUTCHEON: Would you prescribe
30 them for adults?



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COMMISSIONER FURSTBERG: What would they have to pay?

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1 DR. CASTALDI: Well, they certainly would
2 not do any harm. However, there are more interesting
3 studies coming out of the National Institute of Health in
4 the United States of people who have osteoporosis who have
5 fluorides in the water and there are studies where sodium
6 fluoride is being administered to people with osteoporosis;
7 these are older people who tend to get broken bones
8 easily and that has nothing to do with dental health.

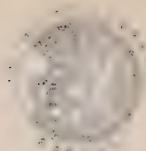
9 COMMISSIONER McCUTCHEON: It does no harm?

10 COMMISSIONER BALTZAN: Did you say sodium
11 fluoride?

12 DR. CASTALDI: Yes.

13 THE CHAIRMAN: Thank you very much. We will
14 take a short recess and proceed with the Alberta Registered
15 Dietitians Association.

16 ---Short recess.
17
18
19
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COMMISSIONER MONTGOMERY: It does no harm?

COMMISSIONER BARTON: Did you say sodium

fluoride?

THE CHAIRMAN: Thank you very much. We will

take a short recess and proceed with the Alberta Register



SUBMISSION OF

ALBERTA REGISTERED DIETITIANS ASSOCIATION

APPEARANCES:

Miss A. Dundas

Mrs. E. Mullen

Mrs. M. Gamble

Miss I. Torrington

Miss R. Crealock

Mrs. E. McGibbon

THE SECRETARY: This will be exhibit 135.

---EXHIBIT NO. 135:

Submission of Alberta
Registered Dietitians
Association.

THE CHAIRMAN: Yes, Mrs. Gamble?

MRS. GAMBLE: Mr. Chairman, we are very
pleased to be here this afternoon to be able to present
this submission from the Alberta Registered Dietitians
Association. The need for dietitians in the province is
extensive and we welcome this opportunity to bring this
need forward formally. I would like to introduce the
delegation with me: Miss Audrey Dundas a past president;
Mrs. Elizabeth Mullen, president of the Edmonton Home
Economics Association; Irene Torrington, president elect;
Miss Ruby Crealock, president; Mrs. McGibbon is acting as
our secretary-treasurer.

The Alberta Registered Dietitians' Associa-
tion is an incorporated professional organization composed
of registered dietitians that serve and protect the public
by means of the practice of dietetics. The business of the
Association is carried on without the purpose of gain for its



APPENDICES:

Mrs. A. Dandee

Mrs. M. Gaudin

Mrs. L. Torrington

THE SECRETARY: What will be exhibit 135?

Submission of Alberta

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of registered dietitians that serve and protect the public

by means of the practice of dietetics. The business of the

Association is carried on without the purpose of gain for



members and any profits to the Association are used in promoting its objectives.

CONCLUSIONS:

1. There is an increasing need for high quality dietetic service and at the moment the outlook for an increase in supply of trained personnel is not too optimistic.
2. The general public is not sufficiently aware of:
 - a. the duties and responsibilities of the dietitian
 - b. the training and education available for dietetics
 - c. the rewarding aspects of the profession.
3. There is a great need for auxiliary assistance from trained dietary personnel such as:
 - a. the certified dietary aide
 - b. the cook with the opportunity to attend institutes dealing with menu planning, purchasing, and the organization of a dietary department.
4. There is a great demand for a special dietary manual geared in particular to the needs of the smaller hospitals.

RECOMMENDATIONS:

The present average of one dietitian to every five hundred hospital beds is hopelessly inadequate. The standard we go by here is one dietitian for every one hundred beds; this has been recently altered to one dietitian for every eighty beds because of the 40-hour week. The optimum standard is one per one hundred.

THE CHAIRMAN: In the hospital system?



members and any profits to the association are used in promoting its objectives.

RECOMMENDATIONS

1. There is an increasing need for high quality dietitians and at the moment the outlook for an increase in supply of trained personnel is not too optimistic.
2. The general public is not sufficiently aware of:
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 - c. the rewarding aspects of the profession.
3. There is a great need for auxiliary assistance from trained dietary personnel such as:
 - a. the certified dietary aide
 - b. the cook with the opportunity to attend institutes dealing with menu planning, purchasing, and the organization of a dietary department.

RECOMMENDATIONS

The present average of one dietitian to every five hundred hospital beds is hopelessly inadequate. The standard we go by here is one dietitian for every one hundred beds; this has been recently altered to one dietitian for every eighty beds because of the 40-hour week. The optimum standard is one per one hundred.

THE CHAIRMAN: In the hospital system?



1 MRS. GAMBLE: Yes.

2 COMMISSIONER BALTZAN: What have you now?

3 MRS. GAMBLE: One for every 500 hospital
4 beds.

5 In fact there are more dietitians in urban
6 areas with the result that there are none at all in many
7 rural hospitals. Therefore, we respectfully recommend that
8 this commission explore every possible means to improve this
9 very necessary service.

10 We offer the following suggestions:

11 1. That every encouragement be given to students
12 to enroll in courses which lead to a degree in
13 dietetics.

14 You may be interested to know that over the past seven
15 years at the University of Alberta there were 152 graduates
16 in the broad field of home economics and only 57 over the
17 past seven years chose dietetics or majored in dietetics.
18 This is only really one-third of the total home economics
19 graduates.

20 2. That consideration be given to overcome adverse
21 publicity at the high school level against Home
22 Economics courses. We deplore the present
23 attitude which suggests that this knowledge is a
24 "frill" or unworthy of consideration by those
25 planning University entrance.

26 If I may just add to this I suggest that every girl whether
27 she become a career woman or a housewife or whatever field
28 she chooses should have a basic knowledge of home economics
29 in all its broad aspects because she will use this.

30 3. That leadership be given to establish courses



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This is only really one-third of the total home economics

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she become a career woman or a housewife or whatever field

she chooses should have a basic knowledge of home economics

in all its broad aspects because she will use this.

3. That leadership be given to establish courses



1 throughout the country to train:

2 a. certified dietary aides

3 b. to give supplementary training to cooks in

4 menu planning and purchasing where needed by
5 means of institutes.

6 4. That financial assistance be considered for:

7 a. additional scholarships for students majoring
8 in dietetics

9 b. the training of certified dietary aides and
10 institutes for cooks

11 c. the publication of a manual to be of special
12 assistance to the small hospital.

13 There are manuals in existence in Alberta
14 today but they are geared in particular to the larger
15 hospital, the needs of the smaller hospital are somewhat
16 different in the dietary field to the needs of the larger
17 hospital.

18 5. That consideration be given to establishing
19 reasonable salary minimums (Appendix III) in
20 order to attract suitable persons to this essential
21 field of health service and that consideration
22 be given to subsidizing those local areas unable
23 to meet these requirements.

24 We would respectfully point out that present salary
25 schedules are considerably lower than other
26 allied professions requiring equal education and
27 training.

28 In the Appendix III we have the recommended
29 salary schedules for registered dietitians here in the
30 province. We want to point out to the Commission this



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1 salary schedule has not been adopted by the Province. We
2 have recommended it and sent it to those parties concerned
3 with the employment of hospital dietitians, but that
4 hasn't been accepted.

5 THE CHAIRMAN: What is it actually?

6 MR. GAMBLE: This varies. Thank you very
7 much.

8 THE CHAIRMAN: Could you expand that, the
9 salary varies, what are the variations?

10 MRS. GAMBLE: Well, you have the different
11 grades. The starting dietitians it is recommended that
12 the juniors, this is on the second last page of the brief,
13 a graduate dietitian junior is recommended as \$380.00
14 per month in the province.

15 MISS DUNDAS: In Edmonton the starting
16 salary varies from \$315.00 to \$320.00 a month in two
17 hospitals I know of for sure.

18 MRS. GAMBLE: In Calgary?

19 MISS TORRINGTON: It is less than that.

20 MRS. GAMBLE: It is less than \$315.00.

21 THE CHAIRMAN: How does it compare with the
22 salary of a registered nurse?

23 MRS. GAMBLE: If I may point out here the
24 average length of training for a registered nurse with
25 non post-graduate work is three years. The average length
26 of training for a dietitian is five years. It is very
27 difficult to compare the starting salary of a registered
28 nurse with three years' training and that of a dietitian
29 with five.

30 THE CHAIRMAN: A graduate nurse after three



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11 grades. The starting dietitian it is recommended that

12 the juniors, this is on the second last page of the brief,

13 a graduate dietitian junior is recommended as \$380.00

14 per month in the province.

15 MISS DUNDAS: In addition the starting

16 salary varies from \$375.00 to \$380.00 a month in the

17 hospitals I know of, for sure.

18 MRS. GAMBLE: In Calgary?

19 MISS FORBES: It is less than that.

20 MRS. GAMBLE: It is less than \$375.00

21 THE CHAIRMAN: How does it compare with the

22 salary of a registered nurse?

23 MRS. GAMBLE: It may point out here the

24 average length of training for a registered nurse with

25 non post-graduate work is three years. The average length

26 of training for a dietitian is five years. It is very

27 difficult to compare the starting salary of a registered

28 nurse with three years' training and that of a dietitian

29 THE CHAIRMAN: A graduate nurse after three



1 goes and gets a job and the dietitian goes and gets a job.

2 MRS. GAMBLE: The registered nurse is lower
3 or comparable depending on the situation, depending on the
4 hospital. It has been fairly comparable, perhaps a little
5 lower.

6 THE CHAIRMAN: Miss Girard?

7 COMMISSIONER GIRARD: I would like to come
8 back to this frill, if you don't mind. The student that
9 is going to take home economics can make her career out
10 of it, why is it considered a frill? It is going to be
11 something utilized. You can make your career with your
12 home economics course. Why would it be considered a frill?

13 MRS. GAMBLE: I want to be sure I understand
14 what your question is.

15 COMMISSIONER GIRARD: The point here, we
16 deplore the present attitude which suggests that this
17 knowledge is a frill or unworthy of consideration by those
18 planning University entrance.

19 MRS. GAMBLE: At the high school level,
20 particularly in Alberta there have been editorials to the
21 effect and discussions to the effect that home economics
22 is a frill in our educational system.

23 COMMISSIONER GIRARD: You mean the part that
24 is given in high schools?

25 MRS. GAMBLE: The high school level.

26 COMMISSIONER GIRARD: Oh yes.

27 MRS. GAMBLE: We are very concerned about
28 this because even a girl in grade nine is thinking about
29 her professional future. This attitude that home economics
30 is a frill and unworthy -- it is not considered an entrance



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1 requirement for university. It is considered an extra
2 subject. In the event a girl wishes to enter university
3 she can still take home economics. It is the attitude at
4 the high school level.

5 COMMISSIONER GIRARD: I am sure this must
6 not come from men.

7 MRS. GAMBLE: Well, some of these principals
8 are men.

9 COMMISSIONER GIRARD: I cannot understand
10 why they would consider something as necessary as this a
11 frill because it is very necessary for every woman to have
12 this.

13 MRS. GAMBLE: That is correct.

14 COMMISSIONER GIRARD: Whatever she goes into
15 she can use it.

16 MRS. GAMBLE: If I may at this particular
17 time point out home economics at the high school level
18 doesn't only include cooking and sewing, although these
19 are very important aspects of home economics, it includes
20 arts and crafts, consumer buying which is how to buy on a
21 budget, and so on, home management, family relationships --
22 the whole aspect of foods and nutritions, all the ramifica-
23 tions of it.

24 COMMISSIONER BALTZAN: Textiles?

25 MRS. GAMBLE: Textiles and clothing.

26 THE CHAIRMAN: It is the University entrance
27 committee or whatever body that the university
28 entrance standards that has to change its attitude.

29 MRS. GAMBLE: I don't know really whether it
30 is the committee. Education over the past few years has



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2 subject. In the event a girl wishes to enter university
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20 budget, and so on, home management, family relationships -

21 the whole aspect of home and nation. All the training

22 is done at it.

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29 is the committee. Education over the past few years has



1 been under a lot of fire as to the type of courses given,
2 home economics and shopwork and so on have been brought
3 up, why take up students' time with these, why not give
4 them more advanced mathematics and more advanced chemistry.

5 THE CHAIRMAN: Or elementary English, is the
6 way I heard it.

7 MRS. GAMBLE: Elementary English.

8 THE CHAIRMAN: The plan has been they have
9 had to set up remedial courses of English and remedial
10 spelling, this kind of thing.

11 MRS. GAMBLE: I really don't feel because
12 a girl takes home economics she is going to suffer in her
13 English if she is a good student.

14 COMMISSIONER GIRARD: Another question,
15 Mrs. Gamble, paragraph 3 on page 2: That leadership be
16 given to establish courses throughout the country to train
17 certified dietary aides. How long would these courses be
18 and in what capacity would they be?

19 MRS. GAMBLE: We now have a committee planning
20 courses in certified dietary aides. We are trying to set
21 up a 32-week course, eight weeks of classroom and twenty
22 practical work, because we feel the practical work, the
23 really on the spot job is very important.

24 COMMISSIONER GIRARD: Would this be mostly
25 for hospital work?

26 MRS. GAMBLE: It is geared largely to the
27 hospital field. It could be adapted to others, but geared
28 to the hospitals now.

29 COMMISSIONER GIRARD: Then, the manual you
30 speak about, financial assistance be considered for the



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1 publication of a manual. I didn't get exactly what kind
2 of a manual you were referring to.

3 MRS. GAMBLE: Miss Crealock knows a great
4 deal about this manual. It is in the process of being
5 written.

6 MISS CREALOCK: This manual we are working
7 on, we have enquiries from a lot of small hospitals in
8 the province, what type of diets are most frequently used.
9 There are not diet manuals for people to use. This has
10 been left to the nurse administrating the hospital or the
11 cook to bring up these diets. There is nothing for them
12 to follow, no dietitians, no visiting dietitians to help
13 them out, so we feel if we can have a simple manual with
14 the diets most frequently called for in the book, simply
15 written so a cook or a dietary aide can follow it it would
16 be a great help to have it. We are working on it now.

17 COMMISSIONER BALTZAN: Do people know about
18 the wonderful manual produced by the dietitians in the
19 Edmonton Hospital. If they don't know I would like to
20 place it on the record.

21 MISS CREALOCK: We know that, but it is
22 too complicated for non-trained personnel to follow. We
23 have to have it simplified so they can read and understand
24 it.

25 COMMISSIONER GIRARD: When we are on this
26 subject are there any present here today that have taught
27 dietetics to nursing students? What is your experience?

28 MRS. GAMBLE: You mean their interest in
29 the course?

30 COMMISSIONER GIRARD: We find nursing students

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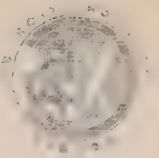


1 usually do badly in dietetics. In my experience we have
2 had all sorts of conferences and workshops with dietitians
3 to see how we can do something about it. What is your
4 experience when teaching dietetics to nursing students?
5 MRS. GAMBLE: I have found a very great
6 deal of enthusiasm providing you can point out to the
7 nurse just exactly where her role comes in and where her --
8 where she fits in to the dietary picture and how very
9 necessary this fitting in is. As soon as you get this
10 philosophy across to her then she is only too willing to
11 get involved in this. I have found that nurses that
12 don't understand this will find this course a wasted hour,
13 let us get through it. If you continually, even in every
14 lecture, get through where you as a nurse on the floor can
15 co-operate with the dietary department or even help the dietary
16 department and help the patient with his diet, understand
17 the diet. You have to reconfirm this because you are
18 so much away from it. The diet kitchen and the diet
19 department is over here and we are over there. You have
20 to be drawing it together all the time.

21 COMMISSIONER GIRARD: Do you feel the
22 success of this course depends on the dietitian who is
23 working with the students or training them to interest
24 them or make this subject better understood by the students.

25 MRS. GAMBLE: That is a difficult question
26 to answer.

27 COMMISSIONER GIRARD: There seems to be a
28 problem, not only in my area where we have discussed it,
29 but in many provinces the nurses have complained, the
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1 good marks and why, and we are trying to find out.

2 MISS CREALOCK: I recall when the anemia
3 diet first came out I was teaching dietetics in the hospital.
4 We were very interested in trying this new diet out. We
5 waited until we got a patient in to try the diet. In the
6 diet kitchen -- the girls used to go up daily and watch
7 the blood count. They were interested. I think things
8 like that make it more interesting and they realize they
9 are doing a job. Special diet work can be very interesting.

10 COMMISSIONER GIRARD: If the person that
11 is teaching is able to bring out that interest.

12 MISS TORRINGTON: May I point out in a
13 lot of hospitals you don't have one dietitian doing the
14 teaching. She has several jobs to do. Maybe she can't
15 give all that enthusiasm and encouragement. There again
16 we come to this lack of dietitians in the province.

17 MRS. GAMBLE: If you have your whole time
18 to devote to a subject you are interested in and not being
19 drawn to three other directions perhaps you can do that
20 good job. One other point the attitude is nutrition
21 and food is something they have known all their lives.
22 There is nothing very new, they feel there is nothing new,
23 what is all this talk about, mother has told me, father
24 has told me about drinking mild and so on. It is up to
25 the dietitian to point out the relationship of this course
26 and their actual nursing field. I remember I was giving
27 a class and no one was interested. I just said what are
28 you getting in the next class. They said we are getting
29 a class on the unwed mothers. I think they were more
30 interested in this aspect of their education, because this



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27 you getting in the next class. They said we are getting

28 a class on the unweaned mothers. I think they were more

29 interested in this aspect of their education, because this



1 is something very new to them whereas what I was giving
2 was very boring. This is a challenge you face all the
3 time.

4 COMMISSIONER GIRARD: I think that is right.
5 Thank you very much, Mrs. Gamble.

6 COMMISSIONER FIRESTONE: Mrs. Gamble, would
7 you or your associates be in favour of a free milk pro-
8 gramme in the public schools in Alberta?

9 MRS. GAMBLE: Nutritionally speaking?

10 COMMISSIONER FIRESTONE: Yes.

11 MRS. GAMBLE: Yes. Economically speaking
12 I couldn't say, but nutritionally speaking it would be
13 excellent.

14 COMMISSIONER BALTZAN: Mrs. Gamble, I see
15 you are concerned with adverse publicity?

16 MRS. GAMBLE: Very much.

17 COMMISSIONER BALTZAN: I remember one other
18 area where it was put, not exactly in that way, the
19 question came up about the probability that the faculty
20 of the university hasn't got too attractive a name, they
21 call it the school of home economics which to some people
22 is just a little more household drudgery. I was told,
23 and others on the Commission have heard that there is a
24 move in the direction to have a better name and studies
25 are being made. After all you have mentioned encouragement
26 in the commercial field, nutrition, textiles. The
27 Department of Home Economics is a pretty broad field?

28 MRS. GAMBLE: Extremely broad.

29 COMMISSIONER BALTZAN: Will you give that
30 also consideration?



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29 Department of Home Economics is a pretty broad field?
30 MRS. GAMBLE: Extremely broad
31 COMMISSIONER BATTMAN: Will you give that
32 also consideration?



1 MRS. GAMBLE: Yes, oh yes. I can definitely
2 see your point there. Other than that there hasn't been
3 enough publicity put forward to explain and to promote the
4 courses offered by the home economics field. I feel very
5 strongly if there was more publicity and more promotion
6 even with the present name, so that this would be brought
7 forward to the average person they would then know what
8 it is all about. They wouldn't just assume what it was
9 about.

10 COMMISSIONER GIRARD: I am sure that would
11 be right.

12 THE CHAIRMAN: What about recruitment for
13 the schools. Are there as many people offering as there
14 are places in the school, that is your graduate school?

15 MRS. GAMBLE: I don't think I am clear on
16 what you mean.

17 THE CHAIRMAN: You have your school of
18 economics at the University of Alberta.

19 MRS. GAMBLE: Yes.

20 THE CHAIRMAN: How many offers do they
21 accept in the first year?

22 MRS. MULLEN: I don't think they have ever
23 turned anyone away.

24 MISS DUNDAS: The year I started we were
25 54 and I think that is one of the largest classes. Over
26 the seven years we have 152 graduates from that course.
27 That makes an average of 20 graduating in recent years,
28 and they can handle at least 55 or more.

29 THE CHAIRMAN: You are asking for financial
30 assistance to be considered for additional scholarships.



MRS. GAMBLE: Yes, oh yes. I can definitely

see your point there. Other than that there hasn't been
enough publicity put forward to explain and to promote the
courses offered by the home economics field. I feel very
strongly if there was more publicity and more promotion
even with the present name, so that this would be brought
forward to the average person they would then know what
it is all about. They wouldn't just assume what it was
about.

COMMISSIONER GIRARD: I am sure that would

be right.

THE CHAIRMAN: What about recruitment for

the schools. Are there as many people offering as there
are places in the school, that is your graduate schools?

MRS. GAMBLE: I don't think I am clear on

what you mean.

THE CHAIRMAN: You have your school of

economics at the University of Alberta.

MRS. GAMBLE: Yes.

THE CHAIRMAN: How many classes do they

MRS. MULLIN: I don't think they have ever

MISS DUNN: The year I started we were

24 and I think that is one of the largest classes. Over

the seven years we have 152 graduates from that course.

That makes an average of 20 graduating in recent years,

and they can handle at least 25 or more.

THE CHAIRMAN: You are asking for financial

assistance to be considered for additional scholarship.



1 There are some available now?

2 MRS. MULLEN: I could speak to that. There
3 are a few available. There is \$100.00 scholarship avail-
4 able in the second year, I believe and one \$50.00 scholar-
5 ship available.

6 THE CHAIRMAN: Any bursaries available for
7 graduate studies, post-graduate studies?

8 MRS. MULLEN: No, and there is no position
9 available in the school for a person to take post-graduate
10 studies as yet. I think there are plans being made.

11 THE CHAIRMAN: Where does the instructional
12 staff in the school come from, I mean the qualifications
13 for the instructional staff? Is there any post-graduate
14 work done at all?

15 MRS. MULLEN: Not as yet. We have one
16 Ph.D. on the staff who has been there two years, I believe
17 and soon they will be able to do something about it. I
18 think the physical set-up at the moment is partly what is
19 hindering this and keeping it from advancing.

20 THE CHAIRMAN: A girl has graduated, some-
21 body has graduated with a degree and wishes to take post-
22 graduate work.

23 MISS TORRINGTON: She either goes to Ontario
24 or the United States.

25 THE CHAIRMAN: You say there are no scholar-
26 ships or bursaries available from Alberta for that type of
27 study?

28 MISS TORRINGTON: Not to our knowledge.

29 THE CHAIRMAN: The \$100.00 bursary does
30 not count.



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THE CHAIRMAN: The \$100.00 bursary goes

not count.



1 MRS. GAMBLE: It certainly doesn't.

2 THE CHAIRMAN: The matter of training of
3 certified dietary aides and institutes for cooks -- are
4 there institutes for cooks in Alberta?

5 MRS. GAMBLE: Right now, we have a member
6 of our Association out at Vegreville speaking to the
7 matrons of the smaller institutes in that area, and some
8 board members, with a view to encouraging these board
9 members to sending these cooks on one day institutes or
10 two day institutes, giving them time off to do this --
11 free time to get away to do this.

12 Right now, there is a great need for these
13 cooks in the smaller hospitals. They have to take on the
14 responsibilities, or an area of the responsibilities of
15 the dietaries, not only do they cook, but they have to
16 look after the special diets, and the running of the whole
17 place and without the assistance of the matron. This is
18 a tall order for anybody, and these cooks have not got
19 the training nor the knowledge, and we want to get
20 institutes to help these cooks with menu planning and so
21 on.

22 THE CHAIRMAN: Where do these cooks come
23 from?

24 MRS. GAMBLE: From the smaller hospitals,
25 sometimes.

26 THE CHAIRMAN: How do they get into the
27 smaller hospitals?

28 MISS CREALOCK: Sometimes they are just
29 homemakers out of a job, they want to earn some money. They
30 have no previous training; just a good cook at home.



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housewives out of a job, they want to earn some money. They

have no previous training; just a good cook at home.



1 THE CHAIRMAN: I suppose that is a good
2 start?

3 MRS. GAMBLE: Yes, it is, but we need a
4 lot of help with budgeting, and menu planning.

5 THE CHAIRMAN: Then, you come into the
6 special dietary business.

7 MISS CREALOCK: Yes, and one problem a
8 cook has is menu planning. She doesn't know how to plan
9 a menu; she doesn't plan menus. Consequently, today she
10 looks in the refrigerator and sees what there is, and
11 that's what you have. Tomorrow, you have what is left
12 over. When there is no more food, buy more food. It is
13 not a well planned and designed menu for good nutrition.

14 MRS. GAMBLE: As far as the financial
15 aspect is concerned, if there could be a watchful eye on
16 the finances of the dietary department, I am sure they
17 would be in favour with this.

18 THE CHAIRMAN: I have not been in a hospital,
19 but I have heard remarks about the fact that meals in the
20 hospital were not the most pleasant thing that the hospital
21 provided. Is that one of the areas in which public
22 relations, so far as a hospital is concerned, is not of
23 the highest order?

24 MRS. GAMBLE: I think this has been picked
25 on and expanded. If I may just say this. I feel this way,
26 that a patient leaving hospital can very easily pick on
27 this particular area to complain about. It is a very easily
28 complainable area. There may be some basis in fact, but
29 I do not think it is as extensive as you would be led to
30 believe.



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believe.



1 COMMISSIONER BALTZAN: In some places, the
2 complaint should go to the doctor, to the diet he prescribed.

3 MRS. GAMBLE: Yes. They say "Oh, this is
4 terrible; what are you giving me?" We say speak to your
5 doctor; don't speak to me.

6 I know a hospital in particular which is
7 famous for good food.

8 MISS TORRINGTON: Well, I think everyone
9 believes themselves to be an expert on food.

10 THE CHAIRMAN: Are there any budgetary
11 limitations on this area on the hospital?

12 MISS DUNDAS: Not on a provincial basis.
13 Each hospital has their own budget, as far as I know, for
14 this. There is not a set meal cost, for a meal, as in
15 some provinces.

16 MRS. GAMBLE: There was one of our statistics
17 quoted as to the percentage of total budget that a dietary
18 department employs, and this is a general one. 50%. Now,
19 it is going to vary in different hospitals.

20 COMMISSIONER GIRARD: You mean 50% for food
21 or for the whole food service?

22 MRS. GAMBLE: Food -- not the whole service.

23 COMMISSIONER GIRARD: Yes. I think we
24 consider food as the elementary service in the hospital,
25 and the service second.

26 MRS. GAMBLE: This was brought out in a
27 Manitoba hospital survey board, who made a survey, and it
28 was 50% for food.

29 COMMISSIONER GIRARD: Just food alone?

30 MRS. GAMBLE: Yes, and there would be more



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28 was 50% for food.
29 COMMISSIONER GIBBARD: Just food alone?
30 MRS. GAMBLE: Yes, and there would be more



1 involved, such as labour and wages and so on.

2 to bring the THE CHAIRMAN: I may not have got the
3 right impression but the other day we heard from the
4 Department that a hospital pays this rated bed day rate,
5 and from which it has to provide the bed whether it is
6 occupied or empty. And, then, the hospital get \$2.00 a
7 day for the maintenace of the patient in the hospital.

8 Is that the fact, that the hospital is
9 expected to maintain the patient within this \$2.00 rate?
10 Has there been any suggestion to the dietary department
11 as to that?

12 MRS. MULLEN: As far as I know, the only
13 hospitals kept on a strict budget, as far as food is
14 concerned, are the mental hospitals. But I think if we
15 all determine our daily food cost, and if it gets out of
16 line, we certainly hear about it. But there is not a
17 certain budget in which we have to keep.

18 THE CHAIRMAN: Thank you very much, Mrs.
19 Gamble and ladies who are with you. As you say, we are
20 all interested in diets, and this will have our considera-
21 tion. If there are any further remarks or observations,
22 we would welcome them from you.

23 MRS. GAMBLE: Just before we leave, I would
24 just like, first of all, to thank you for listening to us
25 today and also, to point out if there is any way, any
26 possibility that we could be included in your report as a
27 need, a health service need, particularly in the Province
28 of Alberta, or if you are going to explore further provin-
29 cial needs, to be included amongst these, because we feel
30 very strongly that in every way possible we want to mention



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very strongly that in every way possible we want to mention



1 this need to try to get more people into the field and
2 to bring the Federal Government to the awareness of this
3 need.

4 THE CHAIRMAN: Very well, Mrs. Gamble.
5 Thank you.

6 Then, we have the Edmonton Family Service
7 Bureau.

8
9 ---EXHIBIT NO. 136: Submission of the
10 Edmonton Family Service
11 Bureau.



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SUBMISSION OF
THE EDMONTON FAMILY SERVICE BUREAU

APPEARANCES: Mr. Jackson N. Willis
Mrs. W. E. Sharpe
Dr. Bernard Kredentser

THE CHAIRMAN: Mr. Willis, are you the
spokesman?

MR. WILLIS: Well, I presume so, Mr.
Chairman. We have submitted through your secretary 25
copies of a very short succinct brief which expresses our
concern for what we call the medically indigent -- I pre-
sume this has not been defined -- but the low income group
of families, and for post hospital or post operative care.
This is a concern we think has been demonstrated in
communities such as Ontario, where the Provincial-Municipal
grant structures have come into being, and where we feel
this kind of thing, because of the mobility of population,
is required on a much broader basis than at present.

Mrs. Sharpe, our homemaker supervisor, has
a couple of cases which will graphically illustrate the
brief, and we will make any further explanation on our part
that is necessary.

MRS. SHARPE: Homemaker Services can be use-
ful and economical adjunct to Health and Welfare Programs
involving:

1. The care of children in their own homes during
the illness of the mother.
2. Helping to maintain old people in their own



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for and economical adjunct to Health and Welfare Programs

1. The care of children in their own homes during

the illness of the mother.

2. Helping to maintain old people in their own



surroundings for a longer period, and

Enabling convalescing patients to return home

at an earlier date, thus releasing hospital beds.

May I refer you to the material submitted earlier which outlines the basic functions, history and development of the Homemaker Service in Edmonton.

In order to illustrate the various areas where Homemaker service can be of immediate and practical use, I would like to present the following case material:

I. M. and F. 5 children, 7, 5, 3, 2, 1 years old.

Mr. S. earns \$300. per month; no prospects of more; Grade VIII education - heavily in debt - at present applying for help to Debtors Assistance Board to bring some sort of order out of chaos.

Living accommodation: rent old shack at \$40. per month. Mr. S. refinished it inside and made it habitable, but no hot water system as yet.

M. - good manager - hard worker and capable - has had a lot of help from her mother and stepfather, but they are unable to continue.

Health problems - Mrs. S. had yellow jaundice December 1960, before birth of last baby; in hospital a month; children placed out among friends and relatives - very unsatisfactory - large medical expenses.

Mrs. S. had all her teeth extracted by private dentist early in 1961 but never able to afford to return for necessary dentures. In meantime took ill in June 1961 with a very serious kidney disease - the doctors feared it might be fatal; on expensive drugs, cortisone, etc. for months - In hospital over 2 months; allowed home

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3. Enabling convalescing patients to return home

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return for necessary dentures. In meantime took ill in

June 1961 with a very serious kidney disease - the doctors

feared it might be fatal; on expensive drugs, cortisone,

etc. for months - In hospital over 8 months; allowed home



1 only if help in the home another 2 months. Homemaker
2 placed June 5/61; and remained in home on a day care basis
3 Monday through Friday until October 6/61, at a cost to
4 Emergency Homemaker Service of \$595.00 (that is, 17 weeks
5 at \$35 per week). We recovered, or rather assessed Mrs.
6 S. \$2.00 per day (that is 17 weeks \$10. per week - \$170.).
7 but as he was unable to pay this even, we reduced it to
8 \$60. to be repaid at \$5. per month.

9 The doctor has advised us he feels that a
10 great deal of Mrs. S's remarkable recovery is due to the
11 fact that she had Homemaker and able to convalesce properly.
12 II Mrs. M. & F. 5 children, 11 years to 1½ years of age:
13 German immigrants. In Canada about 5 years.
14 No relatives or close friends.

15 Mrs. F. good worker, fairly stable and
16 intelligent; income adversely affected by inadequacy of
17 wife to copy, either economically, physically or emotionally
18 with care of children when he is absent from the home. Her
19 overwhelming dependency is debilitating to him and he is now
20 suffering from severe ulcer condition for which he may
21 require hospitalization in near future.

22 Mrs. F. child-like, dependent person with
23 many physical and emotional ills. Has only 10 teeth left
24 and badly needs dental attention; has bad varicose veins
25 which necessitate varicose vein operation as soon as a bed
26 is available in hospital; have been waiting over three
27 months now for a bed.

28 We have placed Homemaker in this home on at
29 least 7 different occasions since 1959 due to the ill health
30 of the mother.





On November 7/61, a Homemaker was placed in the home at the request of the doctor for over 5 weeks - to December 12/61, as Mrs. F. suffering from a blood clot on the leg and it was imperative she should have bed rest to clear up this condition before she could be admitted to hospital for the operation on her varicose veins. This last placement alone cost E.H.S. (5 weeks at \$35.00 per week - \$175.00) - not to mention the previous placements of 1 and 2 weeks time each. We assessed Mr. F. at \$1.00 per day but have recovered very little of this. He earns between \$250 and \$300 per month when he is working but is always heavily in debt and Mrs. F. is not a good manager and has had a great deal of illness, drugs, etc.

III L. - M. & F. Separated and divorcing.

8 children - 7 years to 1 year old.

Finances on the rocks. Mrs. L. to hospital for D. & C. - expected to be only 3 days at the most; turned out to be a major abdominal operation and she was two weeks in hospital and needed another two weeks help at home while convalescing. We put in 24-hr Homemaker for 2 weeks at the cost to us of \$9.00 per day (that is 2 weeks at \$45. per week - \$90.) plus 2 weeks day care at \$30. per week - \$60. Total \$150. We have assessed \$2 per day but have practically no possibility of recovering this. These children were maintained in their own home with relatively little disruption during this period of crisis; until the mother was again able to undertake their care.

This family came from up north; no relatives available able to help.



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1 IV M. - Old Age Pensioners - over 75 years of age:

2 Mr. M. just returned from hospital after
3 serious cancer operation on the bowel - able to be up a
4 little but unable to do anything for himself. Mrs. M.
5 suffering from an ulcerated varicose vein; gets around by
6 using a chair on which she rests her knees and pushes
7 around. Homemaker placed 2 or 3 days a week to do necessary
8 cleaning up, washing, giving Mrs. M. a much needed rest
9 and assistance in care of Mr. M. Cost to E.H.S. \$7.00
10 per day. Assessed old people \$1.00 per day of care.
11 They have two married daughters living in other parts of
12 Canada, who have large families of their own and unable to
13 assist old people

14 Thank you, Mr. Chairman.

15 THE CHAIRMAN: Thank you very much, Mrs.
16 Sharpe. Do you have anything else to add for the moment?

17 MRS. SHARPE: May I add, Mr. Chairman, that
18 we have at present 12 Homemakers on our staff. This is
19 probably in the brief. We started out 15 years ago in this
20 community with 7 Homemakers, and so far have only got to
21 the point of 12 Homemakers, where the population of the
22 city has doubled, I expect, in the last ten years.

23 THE CHAIRMAN: Where do your funds come
24 from?

25 MRS. SHARPE: United Community Fund, plus
26 the fees which we try to recover.

27 THE CHAIRMAN: Yes. From what you have
28 been telling us, you cannot depend on those too much?

29 MRS. SHARPE: Not too much, no.

30 MR. WILLIS: Mr. Chairman, I think our point



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MR. WILLIS: Mr. Chairman, I think our point



1 is this. The Commission, I believe is sitting because
2 health is considered a matter of universal right, and from
3 our point of view the treatment of disease is more than
4 an organic social incapacity as an entity. If you look
5 at the Federal or Provincial or Municipal rates, the costs
6 are exorbitant, but a program like this which permits a
7 family to retain and develop self-sufficiency has not been
8 considered as a health adjunct, and I think it is.

9 In the United States, it is so considered,
10 it has been proven that there is a correlation between
11 chronic invalidism and costs to the government.

12 THE CHAIRMAN: Undoubtedly the Homemaker
13 service has kept that one woman out of hospital for a
14 two-month period, for instance. It is a tremendously
15 greater cost in hospital than with the Homemaker service.

16 In connection with your case work, what
17 do you find about the availability of physician services
18 to those who are, like, these now unable to pay?

19 MRS. SHARPE: Most people who work at any
20 sort of steady employment, many of them, I find, have
21 M.S.I. coverage.

22 THE CHAIRMAN: Even amongst those that your
23 organization comes into contact with?

24 MRS. SHARPE: Not a great many, but those
25 who are working steadily through their employment take
26 out M.S.I. Others, if they are below a very low income,
27 even though not on assistance, can go to the out-patient
28 clinic, I understand, but they have to be below a minimum
29 wage in order to qualify for out-patient.

30 THE CHAIRMAN: Do you find in your experience



is this. The Commission, I believe is sitting; because health is considered a matter of universal right, and from our point of view the treatment of disease is more than an organic social inequality as an entity. If you look at the Federal or Provincial or Municipal rates, the costs are exorbitant, but a program like this which permits a family to retain and develop self-sufficiency has not been considered as a health subject, and I think it is.

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THE CHAIRMAN: Do you find in your experience



1 that some of these people who come under your notice have
2 been without sufficient services for one cause or another?

3 MRS. SHARPE: Yes, we had one just recently
4 where the woman had needed an operation for some time but
5 because of the very poor financial circumstances she had
6 put off doing anything about it. This family was brought
7 to the attention of one of the agencies and they phoned us.
8 One reason she was not ready for hospitalization and
9 operation was because she did not know what to do with
10 her four children, she did not feel that she could afford
11 to pay commercial fees and she did not know about the
12 Homemaker service. She became much worse and the agency
13 that was looking after the family referred them to us
14 and we put a Homemaker in for two weeks while she was in
15 hospital and another week after her return home. She had
16 really avoided doing anything about her condition for a
17 long time mostly because of the cost of the medical or the
18 cost of the care of the children.

19 COMMISSIONER McCUTCHEON: Which was the
20 most important, the cost of the care of the children or
21 the cost of the medical treatment?

22 MRS. SHARPE: Both.

23 COMMISSIONER McCUTCHEON: Equally important?

24 MRS. SHARPE: Yes, I think she could have
25 got the medical attention if her mind had been relieved
26 of the care of the children.

27 COMMISSIONER McCUTCHEON: So the care of
28 the children was the predominating factor?

29 MRS. SHARPE: Yes, I suppose it was.

30 MR. WILLIS: I do not think one can



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1 differentiate the matter of the children from this kind
2 of factor that there should be preventive services given
3 at a given time, that is, if human resources are important
4 and I think they are in this country. I think these things
5 run parallel with the one cost, I do not see how you can
6 separate fees and care of the children.

7 COMMISSIONER McCUTCHEON: Suppose this
8 woman had been insured for medical care on the most
9 comprehensive basis whether she paid or whether it was
10 provided by somebody else, would she still have hesitated
11 about going into hospital until she had been able to
12 arrange for the children?

13 MRS. SHARPE: Yes.

14 COMMISSIONER McCUTCHEON: That is what I
15 mean, it was not the fact that there was no surgeon prepared
16 to operate on her.

17 MRS. SHARPE: No.

18 COMMISSIONER McCUTCHEON: One of those
19 cases you mentioned where you have had the Homemaker in,
20 this woman is on the waiting list. Now to get the patient's
21 place taken care of, they cannot pay for your service but
22 she will still be looked after, in the hospital some
23 surgeon will operate on her?

24 MRS. SHARPE: Yes.

25 THE CHAIRMAN: This matter of the waiting
26 list, do you find people in your agency allowing for
27 finding themselves on waiting lists?

28 MRS. SHARPE: I find this a great deal.

29 THE CHAIRMAN: Do you think they have a
30 lower category on the waiting list than perhaps some other
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29 lower category on the waiting list than perhaps some other
30 section of the community?



1 MRS. SHARPE: My feeling is, I may be wrong,
2 but it is the urgency of the medical attention needed
3 that precludes getting a bed. I get many requests from
4 women who phone and say their doctor has advised them they
5 will be going into hospital within the next week or ten
6 days, as soon as a bed is available could we provide
7 Homemaker services for their children. I assure these
8 women we will do the best we can but they may continue
9 on for two to four weeks. Again, I think it depends on
10 the urgency of the hospitalization but many of them are
11 having to wait that long.

12 COMMISSIONER McCUTCHEON: Wait as part of
13 the general public and not because they are indigent
14 cases who are unable to pay?

15 MRS. SHARPE: It may be if they could have
16 a semi-private ward and many of them have told me if they
17 could have a semi-private they could get in more quickly
18 but because they cannot afford it they have to wait their
19 turn until a bed is available in the ward.

20 MR. WILLIS: One reason for the brevity of
21 our brief was to try to show some of the things that we
22 could document should any member of the Commission choose
23 to walk over to our organization. Some of this has to be of
24 an attitudinal nature and I think these Commissions should
25 be concerned with people outside the major centers where
26 services are not available. A couple of years ago I had
27 occasion to go and live on one of the reservations. At
28 that time in the Indian home where I stayed there were
29 Indian children no different from yours or mine and the
30 kids had measles and the degree of care that was available



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1 for those little kids was not the same as would be avail-
2 able for us, for their parents. I think the Commission
3 should keep this in mind in reading these presentations
4 because most of them are from urban areas and indirectly
5 reflect our thinking, that is the thinking of us who live
6 in cities where facilities are available. The further
7 you move away from the urban centers the worse it becomes;
8 when you get to the sub-marginal incomes in the rural
9 areas it is worse still.

10 THE CHAIRMAN: That is why we appreciate
11 very greatly the attendance of such an organization as
12 yours because you do come to speak for a section of the
13 community that does not speak for itself and which
14 apparently has no voice to speak for it. In a sense you
15 represent these people so any remarks you want to make
16 in line with what you made now are most welcome.

17 MR. WILLIS: One of the things that was
18 asked, the sub-marginal group or indigent group in treat-
19 ment of medical care and I do not intend for my remarks
20 to be made on one side of the philosophical argument or
21 the other. However, I do feel these persons who are indigent
22 or medically indigent, and I don't think the old time
23 term of indigent is adequate any more, I think it is
24 essential that the dignity of these people be maintained
25 the same as for us who have an adequate income. There
26 should be some kind of universal coverage whether it would
27 be under private auspices or government is of little account
28 to me but some principle which permits an individual some
29 choice in where they would go or to whom. All of us have
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1 choice is indicated and it can be a part of the treatment.
2 I think any matter of coverage could take into account
3 that people can be allowed a grant structure at a govern-
4 ment level or a contributory scheme at a private level
5 permit this kind of coverage. I think it is quite a
6 possible thing. Our brief makes reference to the old
7 transient problem and I can recall working for a provincial
8 department of welfare and we had rules A, B and C ad
9 infinitum but it did not do anything. I think the same
10 kind of thing with the majority of our young people in
11 industry and outside of industry is beginning to reflect
12 a very similar problem in health where we are getting
13 graded for degrees of importance.

14 COMMISSIONER McCUTCHEON: What you mean
15 rules A, B and C but it did not do anything, qualifications
16 and urgency?

17 MR. WILLIS: Yes and I think Mrs. Sharpe
18 has given you some cases and I think we could get 100 more
19 in which the young fellow who goes out to work for a
20 company suddenly gets laid off and for some months he is
21 neither fish nor fowl in terms of medical care. I think
22 this kind of thing is something we have to begin to be
23 concerned with.

24 THE CHAIRMAN: Mr. Willis and Mrs. Sharpe,
25 you are dealing with those people who are not able to look
26 after themselves financially or for some other reason and
27 who when they get assistance must show some qualifications
28 for that assistance so we come to the expression the
29 "means test" or "needs test" or something of that kind.
30 What is your experience? Do you find any resentment in the



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What is your experience? Do you find any resentment in the



1 people being asked to disclose their means if they are
2 going to get help?

3 MRS. SHARPE: No, in our particular service
4 people who are already in assistance from either the
5 province or the city in the way of welfare, it is now
6 clarified with both city and province that if the family
7 are in receipt of assistance the province or city will
8 pay us the full Homemaker cost if we put a Homemaker in
9 at their request.

10 THE CHAIRMAN: So that family does not have
11 to worry, they have already been identified?

12 MRS. SHARPE: Yes, and the cost is picked
13 up. As far as we are concerned it is the group in between.

14 THE CHAIRMAN: It is the in between group
15 that we would like to have your experience on.

16 MRS. SHARPE: They are not able to pay
17 completely. I discuss with the father when he applies for
18 Homemaker service about his income and usually they are
19 quite glad to discuss it on the basis we can adjust our
20 fee to what is a reasonable amount from their budget and
21 that is the basis on which we work. This is on the basis
22 of subsidized care because our maximum fee is \$7.00 a day
23 for daytime and \$9.00 for 24-hour care. The average would
24 be much more, it would be more likely to be \$3.00 or \$2.00
25 a day depending on the number of children, how indebted
26 they are, what their income is, how regular their income
27 is and so on. I try to set a fair fee. Also, they are
28 not required to do this all at once, when they are billed
29 they can pay so much a month but most people prefer to
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1 THE CHAIRMAN: What I have in mind at the
2 present time is the attitude at the time they come to
3 you; do you sense that they may hesitate to come for help
4 because of unwillingness to accept charity or unwillingness
5 to have to undergo some form of questioning as to ability
6 to pay?

7 MRS. SHARPE: Yes, I think most people
8 always ask us what our fee is and when they are told they
9 say "I am afraid we cannot pay that". Well then, I say
10 it is possible to adjust this to their income.

11 THE CHAIRMAN: Do you find anybody saying
12 that they would have come to you a month ago only it took
13 them a month to get up enough nerve to do it?

14 MRS. SHARPE: Yes. So many people say
15 "If I had only known of this service when I was last ill
16 and had to place the children with the neighbours". We
17 have not publicized this to any great extent simply because
18 we would be swamped.

19 DR. KREDENTSER: I am just Chairman of the
20 Board and not one of the professional workers in this
21 organization and consequently my knowledge is limited. I
22 just wanted to point out that this service is not
23 publicized in our community. We have only 12 caseworkers,
24 12 Homemakers and if we ever started to publicize this to
25 this middle income group and they knew it was available
26 we could not possibly service them because we could not
27 hire enough Homemakers and pay them their wages. As you
28 notice here we are getting \$1.00, \$2.00 or \$3.00. What
29 we propose is that we would like to maintain this as a
30 private organization within the community by private



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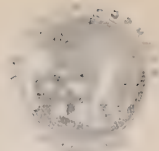


1 individuals such as myself on boards and feeling that the
2 people have the responsibility. Once it becomes a public
3 interest it becomes, like Mr. Willis mentioned, there are
4 rules and things and people are not very interested in
5 going to what you call a charity. Now, people do not
6 feel this way when they come to our office, they feel it
7 is an organization interested in their well being and not
8 in charity. We try to maintain this atmosphere and make
9 sure we give the kind of service by hiring such people as
10 are talking to you today, really give people the feeling
11 of importance. We feel we give a very good service. We
12 try it by representation to public agencies such as
13 provincial and local governments, our position. We feel
14 that our approach is such that they should feel there is
15 some need to give some base to this of financial assistance
16 and not just when you are referring a person in that they
17 should feel a responsibility in this area and a responsi-
18 bility to maintain private enterprise as it is demonstrated
19 by this private agency on a welfare basis.

20 THE CHAIRMAN: As a client comes to the
21 agency they make their own rules in regard to individual
22 care?

23 DR. KREDENTSER: There are different rules,
24 et cetera, but we never turn anyone away, we try not to
25 turn away a needy case. I do not use the word "needy" to
26 mean economics but need because of health reasons. It does
27 not matter whether they come from the highest or lowest
28 income group, the amount they pay depends on what group
29 they come from.

30 COMMISSIONER FIRESTONE: Mrs. Sharpe, if I



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COMMISSIONER WIRSTONE: Mrs. Sharpe, if I



1 understood your correctly you were saying in some of the
2 cases which you mentioned to us that your cost of making
3 that homemaker available to this particular family was
4 about \$35.00 a week. By making this homemaker available,
5 helping the woman after she had come back from the
6 hospital to recover in this two-week period it really
7 made it possible for the woman to leave the hospital a
8 little earlier than would be the case otherwise. Now,
9 it cost \$35.00 to pay the out-of-pocket expenses for the
10 homemaker; if the woman had stayed in the hospital it
11 would have cost roughly \$20.00 a day, perhaps a little
12 less, but something like \$140.00, probably a little less.
13 The difference between \$35.00 and \$140.00 is very sub-
14 stantial, and therefore, there would be a substantial
15 saving involved for the Province of Alberta if this
16 homemaker service was more widespread. We understand
17 that the motives that have been explainted to us why you
18 are keeping this a small group and the difficulties you
19 are facing in recent days, but looking at it from the
20 point of view of the people of Alberta and from the point
21 of view of plain simple economics it would make more
22 sense to spend \$35.00 than \$140.00. Now, if that is the
23 case, I am looking at your figures in your report and you
24 say on page 3:

25 "It is important for the Commission to
26 know that from the years 1958 to 1961 the
27 service turned away as many families as
28 it served, and as well it is important to
29 remember that this service is given
30 absolutely no publicity because of an



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1 earlier demonstration project suggested
2 that we might more than quadruple the
3 number of families making requests."

4 In other words, you are handling with your
5 limited resources only about one-half of the people that
6 came to you and if there had been more knowledge of the
7 service that you would have had four times as many serviced
8 persons as you did. To come back to the earlier question,
9 it would have made economic sense, it would have saved
10 the Government of Alberta and the people of Alberta a lot
11 of money if you had been able to provide those increased
12 services. The question is, why should such increased
13 services not be provided if arrangements can be worked
14 out?

15 DR. KREDENTSER: It is a very good
16 question and I would like an answer to it too. We have
17 a budget of \$80,000.00 which includes both family counsell-
18 ing and the homemaker service and this fund is \$80,000.00
19 and the principle amount is for our staff. Now, we have
20 presented a brief to the -- am I permitted to mention
21 this -- I have to get an okay from my chief -- a brief to
22 the city to try to widen our base of financial assistance
23 because we know there is only so much money you can
24 derive from the United Community Fund, the pot is only so
25 large and our share can only be so much. We realize the
26 need is there and the Board and Staff are trying diligently
27 to widen this base. I would like to have the aid of the
28 Commission to try to widen it if we could.

29 MR. WILLIS: The Chairman raised the
30 matter of means test and eligibility and I think one of



earlier demonstration project suggested

that we might more than quadruple the

In other words, you are handling with your

limited resources only about one-half of the people that

came to you and if there had been more knowledge of the

service that you would have had four times as many services

persons as you did. To come back to the earlier question,

it would have made economic sense, it would have saved

the Government of Alberta and the people of Alberta a lot

of money if you had been able to provide those increased

services. The question is, why should such increased

services not be provided if arrangements can be worked

out?

DR. KRAMER: It is a very good

question and I would like an answer to it too. We have

a budget of \$80,000.00 which includes both family counsellors

and the homemaker service and this fund is \$80,000.00

and the principle amount is for our staff. Now, we have

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MR. WILLIS: The Chairman raised the

matter of means test and eligibility and I think one of



1 the things is that the main part of the question we are
2 trying to save money from some intelligent point of view.
3 No one affiliated with a welfare association is chastized
4 for wanting to spend money but I feel we want to save it.

5 As Dr. Kredentser has
6 said, we have submitted briefs to various levels of
7 government. This particular community represents a
8 national problem. If I had to make that problem
9 something that is a model of the right to the politi-
10 cal thing, and I think is something the Commission
11 rather than ourselves would have to examine beyond that
12 point.

13 COMMISSIONER FIRESTONE: Obviously,
14 we are not concerned with the political implications.
15 We do want to examine what can be done in the situation.

16 As I understand you correctly, you are
17 saying, the implication of what you are saying, was if
18 more money was spent, that more money could be saved?

19 MR. WILLIS: I think so.

20 COMMISSIONER FIRESTONE: Is that
21 what you are saying?

22 MR. WILLIS: I think so.

23 COMMISSIONER FIRESTONE: Translating
24 this, if we had the homemaker service at thirty-five
25 dollars, we would save one hundred and forty dollars in
26 treatment and in hospital stay, or more than four times
27 a saving.

28 MR. WILLIS: I would say, yes.
29 The hospital care costs alone if dollars are the sole
30 thing that is important, then this would be saved.



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1 THE CHAIRMAN: You have kept the
2 family together also.

3 COMMISSIONER FIRESTONE: There are
4 many other ramifications. I am concerned now with
5 economics. Of course, you are concerned with humanitar-
6 ianism and the social service work. We accept that, but
7 trying to limit my question to one limited aspect, if
8 I may, you have, if I understand you correctly, approached
9 the City of Edmonton to see how you can obtain additional
10 funds to expand your homemaker service; is that correct?

11 MR. WILLIS: Yes.

12 COMMISSIONER FIRESTONE: You say the
13 problem which we are facing is that you may have
14 difficulties getting these funds and be unable to expand
15 your services. As a result of you being unable to raise
16 those funds, the hospital programme which the federal
17 and provincial governments are paying is four times as
18 much as it needs be because you would keep these people
19 out of the hospital.

20 The question, therefore, arises;
21 should there be an approach made to the federal and
22 provincial governments on the grounds that it would save
23 them money in the end by decreasing the utilization of
24 hospital beds?

25 MR. WILLIS: The answer, Professor
26 Firestone, is yes, but I think that the way in which
27 this is approached from a small local organization like
28 ourselves, has to be in some direction elsewhere. I
29 would presume the grant directors operate in various
30 patterns. I only know in three provinces. It is basically



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1 local. This is what we are trying to do, put our
2 submission to the municipalities.

3 COMMISSIONER FIRESTONE: You have
4 done so. Have you considered approaching the provincial
5 government on this point?

6 MR. WILLIS: We have at various times
7 been approached by members for the purpose of services.
8 I would reiterate, I think, even locally one must begin
9 in the best way to give you access to a given community.

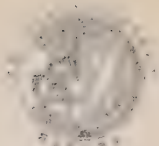
10 COMMISSIONER FIRESTONE: You are
11 offering some advice to a Royal Commission on Health
12 Services which is expected to advise the federal
13 government. What is your advice to us?

14 MR. WILLIS: My advice, Professor
15 Firestone, is contained in the brief. This problem is
16 no longer a local community one or a local provincial
17 one.

18 COMMISSIONER FIRESTONE: Yes.

19 MR. WILLIS: Due to the expansion
20 on this type of service, it becomes larger. A family
21 in Halifax may be a problem for us to deal with tomorrow.
22 It becomes one of federal responsibility. This is
23 everybody's responsibility, therefore, the grant
24 structure should allow for local autonomy at some level
25 and should be geared from the top down. The office boy
26 never tells the corporation manager how to run his
27 organization.

28 I think possibly twenty cents out of
29 the dollar is going this way, federal government tax
30 dollar. I think the tax structure has to be looked at



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1 in the same wholistic approach.

2 COMMISSIONER FIRESTONE: If I
3 understand you correctly, you have accepted the principle,
4 stated the principle to us, that in view of the growing
5 industrialization and expansion of our economy, this
6 problem has become a national problem rather than a
7 local problem. That I think is your point, am I correct?

8 MR. WILLIS: That is correct.

9 COMMISSIONER FIRESTONE: Is your
10 second point in order to find the funds required there
11 should be a share of the increased cost taken by the
12 federal, provincial and local authorities?

13 MR. WILLIS: Geared at the local
14 level.

15 Coming to the Chairman's point on means
16 tests, I think in this culture people prefer to pay for
17 things. The means test is as reasonable as the old
18 Elizabethian idea of getting the wood from one pile to
19 the other. I think the contributions should be geared
20 to allow them to pay part.

21 COMMISSIONER FIRESTONE: We have,
22 therefore, established two principles: The first one,
23 that it is really a federal, provincial and municipal
24 responsibility with all three levels of government
25 participating and with the administration at the regional
26 or local level. Am I correct in that understanding?

27 MR. WILLIS: Yes, but I just added,
28 the individual.

29 COMMISSIONER FIRESTONE: And the
30 individual contributing to the extent that they are



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1 capable of doing so?

2 MR. WILLIS: That is right. It is
3 an individual free enterprise economy, and that kind of
4 thing, I think could be done in other words it is the
5 synthesis that we are trying to work in.

6 COMMISSIONER FIRESTONE: I don't
7 quite get your emphasis on free, individual free enter-
8 prise economy. You have explained a little earlier that
9 this problem has become a national problem and since
10 you are concerned with the incomes of people that are in
11 low income brackets that cannot afford many of the
12 services offered in full or in part that the State
13 should make a contribution.

14 MR. WILLIS: Yes, that is correct.

15 COMMISSIONER FIRESTONE: Is that
16 the situation you have described to us?

17 MR. WILLIS: That is correct.

18 COMMISSIONER FIRESTONE: In a
19 situation like that you expect the state to make a
20 contribution?

21 MR. WILLIS: When I say state I am
22 thinking of where the money -- the thing where the
23 universal privilege of right, the right to pay.

24 COMMISSIONER FIRESTONE: Would you
25 explain to us what you mean by the universal privilege
26 of right?

27 MR. WILLIS: You are trying to
28 guarantee some areas of care. There are many areas --
29 I went into a community that is only a couple of hundred
30 miles outside of Winnipeg. There were forty-five



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2 communicable disease. When this was raised as a public
3 issue, they had thousands of truckloads of toys.

4 The thing I was saying, is there are
5 forty-five children who were suffering this kind of
6 disease, if their parents could pay to assist them --
7 it is geared to the area in which they live. I think
8 it is possible for your tax supported structure to take
9 into account that people can pay to a given degree.
10 I don't think it is necessary to go through a means test.

11 THE CHAIRMAN: Without the means
12 test how do you determine the proportion payable?

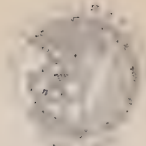
13 MR. WILLIS: You have, for example --

14 THE CHAIRMAN: I don't want you to
15 get the idea any one is advocating or not advocating
16 the means test. We are asking a question. Is it the
17 essence of your proposition that at some stage or
18 another somebody has to apply the means test?

19 MR. WILLIS: Mr. Chairman, in view
20 of the very short notice we were given to make some kind
21 of intelligent, and I hope it is, submission.

22 THE CHAIRMAN: Most intelligent,
23 and we are most grateful to you for it.

24 MR. WILLIS: The details of this
25 thing, it is feasible, it is possible, but to ask how
26 it can be done -- if the Commission will stop by for
27 lunch on its way back from Vancouver we could probably
28 give this information. I think it is possible to get
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1 THE CHAIRMAN: Rather than stopping
2 off, which would be a most pleasant thing, could you
3 send a communication by mail to Ottawa?

4 MR. WILLIS: Yes, I presume I could.

5 COMMISSIONER FIRESTONE: Then if that
6 is the case, I will desist questioning on this particular
7 point, and perhaps refer to some other aspects.

8 We are looking forward, sir, to receiv-
9 ing that communication you indicated you might be able
10 to provide us with.

11 Mrs. Sharpe, coming back to your Case
12 A, you were telling us the head of the family was heavily
13 in debt. Was one of the contributing factors to the
14 heavy indebtedness unpaid medical bills?

15 MRS. SHARPE: Yes, unpaid medical
16 bills and expenses due to illness.

17 COMMISSIONER FIRESTONE: Would that
18 include drugs?

19 MRS. SHARPE: Drugs, yes.

20 COMMISSIONER FIRESTONE: This was a
21 case, if I understood you correctly, that the man used
22 to be employed making \$300.00 a month when he was working,
23 and they presumably had no coverage under M.S.I. or a
24 similar programme.

25 MRS. SHARPE: At that time he didn't.
26 He now has.

27 COMMISSIONER FIRESTONE: He wasn't
28 eligible for social welfare?

29 MRS. SHARPE: No.

30 COMMISSIONER FIRESTONE: Therefore,



THE CHAIRMAN: Rather than stopping

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1 we have a case that presumably there are many in the
2 so-called medical indigent group, that don't have this
3 coverage under M.S.I. or some corresponding coverage,
4 or if they have that coverage, will lose that coverage
5 if they don't pay premiums because they are unemployed.
6 In cases like this I think we have been told that if
7 that man goes to a physician he will generally get
8 medical attention, but the problem still remains at
9 some stage or another he has got to pay for these medical
10 services; is that correct?

11 MRS. SHARPE: Yes.

12 COMMISSIONER FIRESTONE: Would you
13 find, for example, people who are in that case, and their
14 doctor has been looking after, would go out and borrow
15 from different individuals or institutions or small loan
16 companies, banks, with a view to paying their medical
17 bills?

18 MRS. SHARPE: I don't think most of
19 the people; I would feel, & medical indigents to be
20 people who could borrow only from friends or family.
21 They would have no assets whatever to borrow from a bank
22 or finance company. Most of them don't have cars. They
23 definitely don't have property.

24 The ones that I am thinking of are the
25 one young couples in their early or middle twenties who
26 have five or six children and who got married too young
27 to have any educational training or equipment to obtain
28 a better living. They will likely stay at that earning
29 level they are at now, only it will become worse because
30 of the number of the children and the illnesses with



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1 which they are afflicted.

2 Another point, I know of many families
3 that I come in contact with where the physician says
4 they should have a prescription filled and then they
5 are unable to buy the drugs prescribed. I have had this
6 happen many times.

7 COMMISSIONER FIRESTONE: What happens
8 in cases like that?

9 MRS. SHARPE: Well, if they are
10 earning above the maximum allowed by the State Welfare
11 Department they have no recourse.

12 COMMISSIONER FIRESTONE: In other
13 words, the doctor says this particular drug is essential,
14 you must buy it to recover, and that person says, I am
15 sorry, I haven't got the money and I don't know how to
16 get it because I am not a welfare case, and the person
17 leaves it to nature to recover, if they recover?

18 MRS. SHARPE: I know of instances
19 of this, yes.

20 COMMISSIONER FIRESTONE: There is no
21 recourse for these people to get help anywhere.

22 MRS. SHARPE: As far as I know there
23 isn't. I have explored various possibilities by trying
24 to refer them to welfare. They say if they earn such
25 and such an amount they are not eligible for out-patient
26 clinics and they are not eligible for any assistance for
27 drugs as far as I can ascertain.

28 COMMISSIONER FIRESTONE: Well now,
29 Mrs. Sharpe, did you in your experience come across cases
30 where people because they don't have the money to pay a



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Mrs. Sharpe, did you in your experience come across cases

where people because they don't have the money to pay a



1 doctor don't go and see a doctor?

2 MRS. SHARPE: Yes, I think that it
3 it, but I find that most people do have a family doctor
4 that they consult. People with small children have to
5 have a doctor. I think most of them do get medical
6 attention from the point of view of the doctor's
7 willingness to see and to aid, I suppose.

8 COMMISSIONER FIRESTONE: There is no
9 question the doctors have told us, the physicians have
10 told us people that have inadequate means they come to
11 them and they will give them good attention. The
12 problem is really not sick people that go to the
13 physician. They do get attention because the doctors
14 will look after them. The problem primarily may be in
15 the case of indigent people they are hesitant seeing
16 the physician knowing they cannot afford to pay his
17 charges, and if they should require some serious
18 treatment to undergo an operation or whatever it is.

19 MRS. SHARPE: Yes, as I illustrated
20 the woman who wouldn't go to the hospital because she
21 had no one to look after the children.

22 THE CHAIRMAN: This wasn't ---

23 MRS. SHARPE: That case she had been
24 to the doctor. The point is where do you draw the line.

25 COMMISSIONER FIRESTONE: Since my
26 colleague has raised the question we might as well
27 understand the situation. Assuming that this particular
28 person has had medical coverage and therefore would have
29 had no problem in having these doctor bills paid and
30 the surgery involved, and the other drug costs and the



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1 hospital costs, could a family in that case have afforded
2 part of the cost including the home management service,
3 manage that cost knowing the doctor bills and the drug
4 bills and all the other expenses are taken care of?
5 Would they be in a better position to pay for homemaker
6 services?

7 THE CHAIRMAN: Are you talking about
8 a particular case?

9 COMMISSIONER FIRESTONE: I am
10 referring to the case we have been discussing.

11 THE CHAIRMAN: We haven't, the case
12 Mrs. Sharpe has been discussing didn't have her coverage.
13 Personally, Mrs. Sharpe, I don't know how you could
14 answer this, half is hypothetical.

15 MRS. SHARPE: The difficulty, if I
16 may say is that you get in ----

17 THE CHAIRMAN: If you wish to answer
18 it you may. Mrs. Sharpe, your answer is not going to
19 be of any benefit to me. I am only putting it to you
20 that way. Don't stop on that account. You may be able
21 to give some assistance to Professor Firestone.

22 COMMISSIONER FIRESTONE: I would be
23 very happy to have your views, Mrs. Sharpe.

24 MRS. SHARPE: It is impossible to
25 answer that question. What I was going to illustrate,
26 if I may, and this may answer your question in the long
27 run, you take any man earning \$260.00 to \$300.00 and
28 he has got six or seven children, he can barely pay
29 his rent, food, clothing, etcetera for his family.
30 He hasn't got any money left over to pay Homemaker or



hospital costs, could a family in that case have afforded part of the cost including the home management service, manage that cost knowing the doctor bills and the drug bills and all the other expenses are taken care of? Would they be in a better position to pay for home management services?

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COMMISSIONER FIRSTONE: I am

referring to the case we have been discussing.

THE CHAIRMAN: We haven't, the case

Mrs. Sharpe has been discussing didn't have her coverage.

Personally, Mrs. Sharpe, I don't know how you could

answer this, half is hypothetical.

MRS. SHARPE: The difficulty, if I

may say is that you get in ---

THE CHAIRMAN: If you wish to answer

it you may. Mrs. Sharpe, your answer is not going to

be of any benefit to me. I am only putting it to you

that way. Don't stop on that account. You may be able

to give some assistance to Professor Firstone.

COMMISSIONER FIRSTONE: I would be

very happy to have your views, Mrs. Sharpe.

MRS. SHARPE: It is impossible to

answer that question. What I was going to illustrate,

if I may, and this may answer your question in the long

run, you take any man earning \$250.00 to \$300.00 and

he has got six or seven children, he can barely pay

his rent, food, clothing, doctors for his family.

He hasn't got any money left over to pay home manager or



1 anything else. When we assess him possibly a dollar a
2 day or two dollars a day, depending upon the length of
3 time -- if it is only a matter of a week or ten days
4 we feel eventually he may pay us off at \$2.00 a month
5 and he prefers to pay it, most people do. If it is a
6 long term thing such as one we were in, four months --
7 that is very unusual, the average is a month to six
8 weeks -- we couldn't possibly assess him \$5.00 a day,
9 \$3.00 a day. We have got to keep it within the realm
10 of possibility. That is why we sometimes have a set
11 amount and he can pay this up. I don't think the person
12 could afford to.

13 COMMISSIONER BALTZAN: What you
14 really need is free service?

15 MRS. SHARPE: Free service available
16 at relatively little if any cost.

17 COMMISSIONER BALTZAN: Or better
18 wages or continual employment?

19 MRS. SHARPE: Or better training to
20 equip him to earn better wages.

21 COMMISSIONER FIRESTONE: To come
22 back to the question of health services, I assume many
23 people, the group of people which I think Mr. Willis
24 described as medically indigent, get incomes of such
25 minor proportions and their payments in terms of family
26 and number of children are such that there just isn't
27 enough income left to pay for medical care services,
28 drugs, dental services, nursing services, homemaker
29 services, and so on, and therefore, there is a definite
30 need to have a scheme which would take care of the



anything else. When we assess him possibly a dollar a day or two dollars a day, depending upon the length of time -- if it is only a matter of a week or ten days we feel eventually he may pay us off at \$2.00 a month and he prefers to pay it, most people do. It is a long term thing such as one we were in, four months -- that is very unusual, the average is a month to six weeks -- we couldn't possibly assess him \$2.00 a day, \$3.00 a day. We have got to keep it within the realm of possibility. That is why we sometimes have a set amount and he can pay this up. I don't think the person could afford to.

COMMISSIONER BALDWIN: What you

really need is free service?

MRS. SHARPE: Free service available

at relatively little in any case.

COMMISSIONER BALDWIN: Or better

wages or continued employment?

MRS. SHARPE: Or better training to

equip him to earn better wages.

COMMISSIONER THIRSTON: To come

back to the question of hostel services, I assume many

people, the group of people which I think Mr. Willis

described as medically indigent, get incomes of such

minor proportions and their payments in terms of family

and number of children are such that there just isn't

enough income left to pay for medical care services,

and so on, and therefore, there is a definite

need to have a scheme which would take care of the



1 health requirements of those people that cannot afford
2 to pay out of their earnings their share of the costs.
3 Is that the principle of what you are telling me?

4 MRS. SHARPE: Yes.

5 COMMISSIONER FIRESTONE: My last
6 question, Mr. Willis, your group, as you have explained
7 in answer to a question by the Chairman, is fairly
8 familiar with the health needs of the consumers of
9 health services, particularly families in low income
10 categories. Would you say that taking in account all
11 the needs of this group, this is in the urban areas and
12 in the rural areas, with a comprehensive, pre-paid
13 medical care services plan, it must be by the province,
14 that people that can afford to pay, pay and those that
15 cannot afford, have it paid by the state. Would that
16 meet the real needs of the people of Alberta?

17 MR. WILLIS: Mr. Firestone, you are
18 asking me to deal in conclusions and it seems to me the
19 Commission is here to examine possibilities. I think,
20 your term, a comprehensive pre-paid plan -- it must be
21 by the province -- I don't know if I would arrive at
22 that particular conclusion. There must be local autonomy.
23 I would hold with contributions.

24 I use the term individual rights,
25 individual responsibility, and I would hold with that
26 term. So, it may be a comprehensive pre-paid plan
27 administered by the private practitioners or a special
28 commission, or any number of things. I would not rule
29 on that. But a comprehensive plan, yes, when people
30 are in this low income group and are not able to pay,



health requirements of those people that cannot afford to pay out of their earnings their share of the costs.

Is that the principle of what you are telling me?

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in answer to a question by the Chairman, is fairly

familiar with the health needs of the consumers of

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categories. Would you say that taking in account all

the needs of this group, this is in the urban areas and

in the rural areas, with a comprehensive, pre-paid

medical care services plan, it must be by the province,

that people that can afford to pay, pay and those that

cannot afford, have it paid by the state. Would that

meet the real needs of the people of Alberta?

MR. WILLIS: Mr. Stonehouse, you are

asking me to deal in conclusions and it seems to me the

Commission is here to examine possibilities. I think,

your term, a comprehensive pre-paid plan -- it must be

by the province -- I don't know if I would arrive at

that particular conclusion. There must be local autonomy.

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administered by the private practitioners or a special

commission, or any number of things. I would not tie

on that. But a comprehensive plan, yes, when people

are in this low income group and are not able to pay,



1 and that there is a need for this comprehensive plan.

2 I would say a comprehensive programme,
3 but beyond that I could not say.

4 COMMISSIONER FIRESTONE: How would
5 such a comprehensive medical care programme as you
6 envisage be financed as far as the requirements of those
7 people are concerned that do not have adequate income
8 in the case which Mrs. Sharpe described?

9 MR. WILLIS: On this basis, then,
10 it would be possible for a province -- and we have
11 something like that here, although it is not as grand,
12 I do not think as it has been cited, where the provincial
13 authorities for the truly indigent in the legal sense
14 of indigent can pay a contributed amount. So that it
15 is comprehensive coverage, as such, perhaps, for this
16 group which is suffering. If there is any kind of
17 set back to their personal economy -- and for the person
18 who is able to pay, to pay it themselves.

19 COMMISSIONER FIRESTONE: If I
20 understand correctly, your suggestion is that the
21 provincial government, or, under this scheme which you
22 envisage, the requirements of those that are welfare
23 cases would be covered as they are now, and the medically
24 indigent group that cannot afford to pay the cost,
25 their cost would either be paid in full or in part by
26 the state?

27 MR. WILLIS: That is correct.

28 I would like to add one point from
29 what Dr. Kredentser said in view of your question
30 pertaining to economics, and that is that our brief is



and that there is a need for this comprehensive plan.
I would say a comprehensive programme,
but beyond that I could not say.

COMMISSIONER FIRESTONE: How would

such a comprehensive medical care programme as you
envisage be financed as far as the requirements of those
people are concerned that do not have adequate income
in the case which Mrs. Sharpe described?

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I do not think as it has been cited, where the provincial
authorities for the truly indigent in the local sense
of indigent can pay a contributed amount. So that it
is comprehensive coverage, as such, perhaps, for this
group which is suffering. If there is any kind of
set back to their personal economy -- and for the person
who is able to pay, to pay it themselves.

Understand correctly, your suggestion is that the
provincial government, or, under this scheme which you
envisage, the requirements of those that are well-to-do
cases would be covered as they are now, and the medically
indigent group that cannot afford to pay the cost,
their cost would either be paid in full or in part by
the state?

I would like to add one point from
what Dr. Knechtger said in view of your question
pertaining to economics, and that is that our brief is



1 submitted on the basis that this programme, as we offer
2 it, is to try to suggest to the Commission, again, the
3 wholistic approach to the treatment of disease, this
4 treatment we are interested in. It is possible to take
5 someone into hospital, for hospital care cost to be high,
6 to cure them in that sense, but to leave these things
7 that are costly which arrive out of an incomplete
8 medical care plan, we are asking the Commission to
9 consider that adequate treatment facilities for Canadian
10 families to take care what we are trying to take care
11 of and that is the indigents and the dependents and
12 the disordered behaviour, arising from an incomplete
13 non-comprehensive medical care programme.

14 COMMISSIONER McCUTCHEON: I want to
15 go back to one point, Mrs. Sharpe. I think you answered
16 it twice.

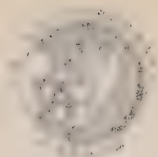
17 If there was a comprehensive pre-paid
18 medical care programme to which the family that we were
19 discussing, under which they were covered, that would
20 still require your service. Before that mother went
21 into hospital, am I right in that that they might still
22 find great difficulty in paying for it?

23 MRS. SHARPE: Yes.

24 MR. McCUTCHEON: They still might
25 not be able to pay the full rate?

26 MRS. SHARPE: Oh, yes, that is
27 right .

28 THE CHAIRMAN: I want to thank you
29 very much for being here. You were invited to come to
30 give us information on the need at this level.



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submitted on the basis that this programme, as we offer it, is to try to suggest to the Commission, again, the wholistic approach to the treatment of disease, this treatment we are interested in. It is possible to take someone into hospital, for hospital care cost to be high, to cure them in that sense, but to leave those things that are costly which arrive out of an incomplete medical care plan, we are asking the Commission to consider that adequate treatment facilities for Canadian families to take care what we are trying to take care of and that is the individuals and the dependents and the disordered behaviour, arising from an incomplete non-comprehensive medical care programme.

COMMISSIONER OF MEDICINE: I want to go back to one point, Mrs. Sharpe. I think you answered it twice.

If there was a comprehensive pre-paid medical care programme to which the family that we were discussing, under which they were covered, that would still require your service, before that mother went into hospital, am I right in that that they might still find great difficulty in paying for it?

MR. MACDONALD: They still might not be able to pay the full rates.
MRS. SHARPE: Oh, yes, that is

right.
THE CHAIRMAN: I want to thank you very much for being here. You were invited to come to give us information on the need at this level.



I think we have taken advantage of
your good nature, and we have questioned you extensively
on areas which you were not asked to inform yourself on.
I mean, in these economic aspects. But, you have been
most helpful to us and we are very grateful to you for
having been here, and for the very helpful views which
you have expressed.

MR. WILLIS: Thank you very much,
Mr. Chairman.

--- Adjournment.



I think we have taken advantage of
your good nature, and we have questioned you extensively
on areas which you were not asked to inform yourself on.
I mean, in these economic aspects. But, you have been
most helpful to us and we are very grateful to you for
having been here, and for the very helpful views which
you have expressed.

WILLIS: Thank you very much.

Mr. Chairman.

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

EDMONTON

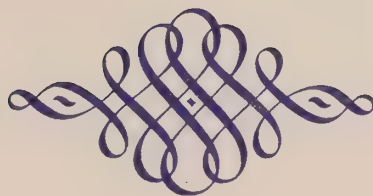
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SUBMISSION

THE ASSOCIATED HOSPITALS OF ALBERTA

COUNCIL OF COMMUNITY SERVICES OF
EDMONTON AND DISTRICT

EDMONTON CHAMBER OF COMMERCE

CHARTERED PHYSIO-THERAPISTS OF ALBERTA

CANADIAN PUBLIC HEALTH ASSOCIATION

LETTER OF THE ALCOHOLISM FOUNDATION
OF ALBERTA



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VOLUME 26

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the Hearing
held in Edmonton, Alberta
16th day of February, 1962

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL - Chairman
MISS ALICE GIRARD, R.N.
DR. DAVID M. BALTZAN
PROF. O.J. FIRESTONE
MR. M. WALLACE McCUTCHEON, Q.C.
DR. C.L. STRACHAN
DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE

ROYAL COMMISSION ON HEALTH SERVICE

Proceedings of the Hearing
held in Edmonton, Alberta
15th day of February, 1966

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL - Chairman
MISS ALICE GIRARD, R.N.
DR. DAVID M. BALTAN
PROF. O.J. FIRESTONE
MR. M. WALLACE ROBERTSON, O.C.
DR. C.L. STRACHAN
DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, O.C.

MEDICAL CONSULTANT:

DR. PIERRE JOUIN

DIRECTOR OF RESEARCH:

SECRETARY:

MR. H. LAIRANCE



Edmonton, Alberta
Friday, February 16, 1962

THE CHAIRMAN: We will proceed with the
submission of the Associated Hospitals of Alberta.

---EXHIBIT NO. 137: The main Submission of the Associ-
ated Hospitals of Alberta.

---EXHIBIT NO. 137A: Supplement to the Main Submission
of the Associated Hospitals of
Alberta.

APPEARANCES:

CHIEF JUDGE N.V. BUCHANAN

DR. J.D. WALLACE

REV. SISTER MARY

DR. IRIAL GOGAN

MR. WALTER MADAY

MR. J.A. MONAGHAN

MR. L.A. QUAGLIA

MR. MURRAY ROSS

DR. J.C. JOHNSTON

MR. WALTER T. ENGELSTAD

MR. G.C. SHERWOOD

CHIEF JUDGE BUCHANAN: Mr. Chairman and
Members of the Commission, the President of the Associ-
ated Hospitals of Alberta, Mr. Carlson, a farmer from
the southern part of the province, is basking in the sun-
shine at Honolulu unaware, I think, of the precise date
at which the Commission would sit.

The Vice-President, L.R. Adshear, the ad-
ministrator of the new Foothills Hospital at Calgary, is
in Ontario seeking the latest in equipment for his new
hospital. And, as a Vice-President and Past President,
by the way, of Associated Hospitals of Alberta, it is
my privilege to initiate the proceedings this morning on



Memorandum

THE CHAIRMAN: We will proceed with the

submission of the Associated Hospitals of Alberta.

---EXHIBIT NO. 137: The Main Submission of the Associated Hospitals of Alberta.

---EXHIBIT NO. 137A: Supplement to the Main Submission of the Associated Hospitals of Alberta.

APPROXIMATE:

CHIEF JUDGE M.V. BUCHANAN

DR. J.D. WALLACE

REV. SISTER MARY

DR. IRVING COHEN

MR. WALLACE (AGONY)

MR. L.A. QUARLES

MR. MURRAY ROSE

DR. J.C. JOHNSTON

MR. MARTIN T. ECKHART

MR. S.C. (SILVERWOOD)

CHIEF JUDGE BUCHANAN: Mr. Chairman and

Members of the Commission, the President of the Associated

Hospitals of Alberta, Mr. Jackson, a former member

of the southern part of the province, is speaking in the same

shine at Hamilton tonight, I think, of the precise date

at which the Commission would sit.

The Vice-President, L.R. Anderson, the as-

ministrators of the new Footville Hospital at Calgary, is

in Ontario seeking the latest in equipment for his new

hospital. And, as a Vice-President and past President,

by the way, of associated hospitals of Alberta, it is

my privilege to initiate the proceedings this morning on



1
2
3 behalf of the Associated Hospitals of Alberta. If I may,
4 sir, I would like to introduce the panel, all of whom,
5 unlike myself, are fairly familiar with the administration
6 of hospitals. Trustees generally, as you may have dis-
7 covered, sir, in your capacity as a Board Chairman, are
8 not supposed to be any too well informed.

9 Reverend Sister Mary, the Sister Superior of
10 St. Joseph's Hospital at Barhead: Mr. Quaglia, the
11 Assistant to the Executive Secretary of Associated
12 Hospitals; Mr. Joe Monaghan, who is the administrator of
13 Blue Cross in this province, Mr. Maday, whose face and
14 performance, sir, you are already familiar with; Dr. I.
15 Gogan, who acquired his knowledge of hospitals in your
16 province, and now exercises it at the Holy Cross in
17 Calgary; Dr. Wallace, the administrator, with whom you
18 are also familiar, with the University Hospital; Mr.
19 Murray Ross, the Executive Secretary of the Associated
20 Hospitals of Alberta; Dr. Johnston, who administers the
21 General Hospital in Calgary; Mr. Engelstad, one of the
22 Assistant Administrators of the Royal Alexandra Hospital
23 in this city; and Mr. George Sherwood, who is the busi-
24 ness administrator of the University Hospital, Edmonton.

25 I wish to say, sir, that Associated Hospitals
26 of Alberta is a body corporate incorporated by Act of
27 the Legislature of this province. Its affairs are ad-
28 ministered by a Board of 13, representative of the vari-
29 ous varieties of hospitals that we have in this province,
30 and also of the province geographically. The powers of
the Board will be found in the Act, a copy of which is
furnished to you. One of the particular powers is to
set up a Blue Cross Plan, and that was done. Mr.

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behalf of the Associated Hospitals of Alberta. If I may, sir, I would like to introduce the panel, all of whom, unlike myself, are fairly familiar with the administration of hospitals. Trustees generally, as you may have discovered, sir, in your capacity as a Board Chairman, are not supposed to be any too well informed.

Reverend Sister Mary, the Sister Superior of St. Joseph's Hospital at Barhead; Mr. Gualia, the Assistant to the Executive Secretary of Associated Hospitals; Mr. Joe Morgan, who is the administrator of Blue Cross in this province, Mr. Massey, whose face and performance, sir, you are already familiar with; Dr. I. Gogan, who acquired his knowledge of hospitals in your province, and now exercises it at the Holy Cross in Calgary; Dr. Wallace, the administrator, with whom you are also familiar, with the University Hospital; Mr. Murray Ross, the Executive Secretary of the Associated Hospitals of Alberta; Dr. Johnston, who administers the General Hospital in Calgary; Mr. Engelstad, one of the Assistant Administrators of the Royal Alexandra Hospital in this city; and Mr. George Sherwood, who is the business administrator of the University Hospital, Edmonton. I wish to say, sir, that Associated Hospitals

of Alberta is a body corporate incorporated by Act of the Legislature of this province. Its affairs are administered by a Board of 13, representative of the various varieties of hospitals that we have in this province, and also of the province geographically. The powers of the Board will be found in the Act, a copy of which is furnished to you. One of the particular powers is to set up a Blue Cross Plan, and that was done. Mr.



1
2
3 Monaghan is the Administrator of that Plan.

4 One comment I would like to make, sirs.
5 There have been criticisms I note from the newspapers
6 and from appearing here on Monday of the Hospital In-
7 surance Plan which prevails in this province. It should
8 be frankly stated that if the opinion of the panel were
9 sought, they would have to say or admit that in their
10 opinion the Hospital Insurance Plan in this province is
11 possibly the finest in Canada. It is unique in that it
12 provides for the capitalization and the payment of
13 capital costs, which, if I am correct, no other plan
14 does.

15 On the other hand, I would not leave with
16 you the impression that the plan is perfect, and I hope
17 that in the presentation this morning some of the defi-
18 ciencies which we think should be cured and can be cured,
19 we would try to demonstrate how that can be done.

20 The Committee which drafted the brief which
21 will be presented to you was chaired by Dr. Wallace, and
22 I would now ask Dr. Wallace to introduce the brief, if
23 I may.

24 DR. WALLACE: Mr. Chairman and Members of
25 the Royal Commission, I would like to enter two exhibits,
26 if I may. Exhibit 137-B is the Act of Incorporation;
27 Exhibit 137-C is the terms and conditions of the Alberta
28 Blue Cross Plan.

29 ---EXHIBIT NO. 137-B: Act of Incorporation.

30 ---EXHIBIT NO. 137-C: Terms and Conditions of the
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Monsieur is the Administrator of that Plan.

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1
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3 The Committee that prepared the brief, as
4 you have read and will hear today, operated more or less
5 by remote control.

6 Most of us are busy people, and we were
7 scattered across the province, and therefore undoubtedly
8 you would expect errors, and these have occurred.

9 The first major error was the failure to
10 follow the rules prescribed in the Privy Council Order,
11 and we therefore felt it was necessary to send a supple-
ment, which I hope that you have all received.

12 Unfortunately, the supplement now causes
13 some confusion in numbering in this brief, and as a re-
14 sult the final product is not of as high a quality as we
15 would have hoped.

16 However, I am sure that the material contained
17 in it will be readily referred to. In the particular
18 copy I received after the ones were sent to you, I found
19 that some of the pages were upside down. I sincerely
20 trust that our case has not been complicated by this
happening in briefs that you have received.

21 The specific corrections: Page 1 of the
22 supplement, the first page of the brief: At a meeting
23 held recently of the group that you see before us, it
24 was indicated that conclusion no. 1 might be interpreted
25 to indicate that this Association is urging a compre-
26 hensive medical care plan or comprehensive health care
27 plan for Canada. I would hasten to indicate this is not
28 the case. It was included to indicate that the Associated
29 Hospitals of Alberta would be happy to co-operate with
30 the government and the medical profession in any

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endeavour they may have at a later date in increasing the health services.

We take the attitude we are in it now anyway, so we will go along in the best way we can with any of the future plans and co-operate with them.

The brief in general does not indicate any general disagreement with the hospital plan in Alberta. As outlined with our chairman we feel that it is a basically good plan, and we disagree mainly with the method in which it is being financed, with the stress placed on cost and very little interest paid to quality of care.

As hospital people, our major concern, perhaps, is quality of care and we therefore feel that a more equal balance should be obtained between these two important features.

I have been appointed to designate a member of our panel to provide an answer to any questions you may have.

Before we proceed further, sir, I would point out that approximately one-third of our hospitals are voluntary hospitals, and in a deficit financing position. They are at an even worse disadvantage than the municipally owned hospital.

Sister Mary is a Past President of our Association, and I would ask Sister Mary to present a special bit of information on the voluntary hospital problem.

SISTER MARY: Mr. Chairman, and members of the Commission, speaking on behalf of the voluntary



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problem.

SISTER MARY: Mr. Chairman, and members of

the Commission, speaking on behalf of the voluntary



1
2
3 hospitals for the Province of Alberta, as Dr. Wallace
4 has stated, approximately one-third of our hospitals are
5 voluntary hospitals. I represent the Sister-operated
6 hospitals. There are several hospitals associated with
7 other Church denominational bases besides Sister-operated
8 hospitals. I would like to include them in my remarks.

9 We believe that the aims of our Canadian
10 hospital insurance plans are in accordance with the
11 fundamental precepts of a Christian social philosophy as
12 set forth very succinctly in the recent encyclical of
13 Pope John the 23rd, entitled "Mater et Magistra".

14 Voluntary hospitals have accepted the hospitalization
15 program as a whole, provided they can maintain and enjoy
16 an effective autonomy to pursue their own specific in-
17 terests always subordinate of course to the common good
18 of society. Theoretically then, voluntary hospitals have
19 no fault to find with the hospital insurance plan for the
20 people of this country. It is in the field of activating
21 or carrying out the plan that difficulties have arisen.

22 Let us discuss for a moment the specific area
23 of excess costs. The plan, as developed in Alberta, is
24 based on the premise that all hospitals will receive the
25 same benefits and it will be enabled to function so as to:

26 1. give good quality of patient
27 care

28 2. carry on education and research

29 3. give service to the community.

30 Inequality in regard to voluntary hospitals
has arisen in the area of operating costs. If a hospital
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hospital for the Province of Alberta, as Dr. Wallace has stated, approximately one-third of our hospitals are voluntary hospitals. I represent the Sister-operated hospitals. There are several hospitals associated with the University of Alberta. I would like to include them in my remarks.

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3 government with regard to its operations, then what it
4 costs the hospitals to operate over and above that
5 amount is entitled an "excess cost". These costs have
6 to be met somehow, as they represent the monies already
7 paid. The municipal hospitals have traditionally a method
8 whereby they may requisition tax monies from their res-
9 pective municipalities for these excess costs. However,
10 the voluntary hospitals do not enjoy like privilege.
11 It has even been suggested, from time to time, that
12 Sisters use their salaries to meet the excess costs of
13 their hospitals.

14 The whole question of Sisters' salaries has
15 several issues; besides being a requisition of monies
16 which no longer belong to the hospital, Sisters' salaries
17 nowadays represent a very small percentage of the hospi-
18 tal payroll. This amount, even if paid back in total to
19 hospital operations, would not cover the excess costs.

20 An attempt at a solution of this problem of
21 possible excess costs in voluntary hospitals, was to
22 pass Legislation in The Alberta Hospitals Act of 1961
23 under Section 11, whereby a voluntary hospital might
24 requisition tax monies if it relinquished control to a
25 Board of Management, the majority of the members of such
26 Board to be representatives of the municipal bodies.
27 Voluntary hospitals are not prepared to give up the right
28 of selecting their own governing Board nor the controlling
29 vote in the decision of such a Board. The Legislation as
30 it stands is therefore ineffectual; we have been assured
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3 The history of hospitals in our country tells
4 of years of dedicated service of courageous women who
5 undertook to build and staff hospitals, equip them and
6 run them economically, so that the ministry to the sick
7 would be carried on. All that these Sisters desire in
8 their work of mercy is to be allowed to continue, moving
9 along of course with the medical and technical progress of
10 the time, but they must be free to do this and not be
11 continually hampered by the lack of operating funds.
12 The ultimate result of such financial bankruptcy from year
13 to year would be to abolish the Sister hospitals, a con-
14 tingency which no one wants to accept, but with which the
Sisters are faced at the present time.

15 In the matter of construction of hospitals,
16 the Sisters have had to conform to government and com-
17 munity planning, something desirable in itself, perhaps,
18 however, there has been no consideration given in this
19 province to providing chapels to those voluntary hospitals.
20 Everyone concedes that the whole man must be cared for
21 in any comprehensive health service today, yet more and
22 more we are faced with the dichotomy of separating body
23 from soul, for the good of both are interdependent. The
24 Sisters ask why we cannot continue to carry on our spiri-
25 tual ministrations in a Christian atmosphere. Why can-
26 not we have the solace of religion for our patients and
for ourselves through the continued provision of chapel
facilities?

27 THE CHAIRMAN: Dr. Wallace, is there any
28 further supplementary statement to be made?

29 DR. WALLACE: I do not believe so, sir.
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3 THE CHAIRMAN: I know the records show this
4 but for the purpose of just having information before
5 us, the hospitals of the province divide into two cate-
6 gories; you have a number of what you might call large
7 hospitals and a number of smaller hospitals. Basically
8 what is the division in numbers?

9 DR. WALLACE: 180 beds is the division.

10 THE CHAIRMAN: And how many are there over
11 180 beds and how many under?

12 DR. WALLACE: 11 over 180.

13 THE CHAIRMAN: And how many under?

14 DR. WALLACE: Active treatment would be 92,
15 I believe in that vicinity. I believe it is 92 in that
16 immediate vicinity and then there are chronic.

17 THE CHAIRMAN: To what bed capacity do they
18 go down to? It is 10, 15, 25?

19 DR. WALLACE: I think the smallest one is 9
20 beds. The group below 180 are divided into sub groups
21 and there are 3 sub groups. Bed capacities might be of
22 interest; one to nine group, 24 beds and there are only
23 three hospitals between 1 and 9 beds. From 10 to 24 beds
24 there is a total of 520 beds in 30 hospitals. In the
25 25 to 49 bed group there are 1,274 beds, 37 hospitals.
26 The 50 to 99 beds, 1,363 beds in 21 hospitals. 100 to
27 199 beds -- unfortunately this figure overlaps the 180
28 -- there are 713 in 5 hospitals. There is one hospital
29 between 200 and 299 and it has 243 beds and above that
30 there are 5 hospitals with a total of 2500 beds for a
total in 1960 of 7,598.

COMMISSIONER BALTZAN: 200 to 299, how many

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COMMISSIONER BATTAN: 200 to 299, how many



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3 hospitals is it?

4 DR. WALLACE: Which group was it?

5 THE CHAIRMAN: 100 to 199 there were 713
6 beds and five hospitals. Then, in the next category
7 there is one hospital with 293 beds and in the final
8 category the five large hospitals 2500 beds.

9 DR. WALLACE: 2,456 to be exact.

10 THE CHAIRMAN: Now, Sister Mary, do the
11 voluntary hospitals come in any particular group in these
12 categories? Are they in a large group or are they spread
13 down through the whole area?

14 SISTER MARY: They are spread through the
15 whole area. There are four larger hospitals and the other
16 hospitals are, I would say, in the 100 to 25 bed group.

17 THE CHAIRMAN: And how many voluntary hospitals
18 are there in the province?

19 SISTER MARY: 36, I believe -- 38.

20 THE CHAIRMAN: Now, taking the last year for
21 which figures would be available, what is the result in
22 terms of either surplus or deficit in the voluntary
23 hospitals for the last year for which complete figures
24 are available?

25 MR. ROSS: We do not have the voluntary
26 hospital figures separate from other hospitals.

27 THE CHAIRMAN: What do you mean by that?

28 MR. ROSS: Well, I can give you an approxi-
29 mation of the deficits of all hospitals in the province
30 but I do not have them broken down as between voluntary
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MR. ROSS: In 1960 it was \$729,000.00 in round figures in 34 hospitals. The year before, in 1959, the amount was \$781,000. I cannot give you the number of hospitals that were involved in that. In respect to the last year, 1961, these of course are incomplete figures because final adjustments have not been made on them. However, from the figures reported by the hospitals it would appear that at December 31 there was a deficit of about \$2,425,000. spread among 92 hospitals. Again I emphasize that that is before final adjustments are made on their accounts. That just relates to basic payments that these hospitals have received, the interim adjustment payment that they receive as income against their total cost of operation they ended up that much behind on that basis at the end of the year. They will receive substantial amounts of that in an adjustment figure.

THE CHAIRMAN: When are those adjustments made?

MR. ROSS: When audited financial statements for the year are available to the Department of Public Health, Hospitals Division.

THE CHAIRMAN: And at what time of the year?

MR. ROSS: It can vary a little in time. They can start working on this because they will have received now a number of audited statements but about this time of the year until the end of March is when these adjustments are made.

THE CHAIRMAN: Some time in the first three months of the year?

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3 MR. ROSS: Yes.

4 COMMISSIONER VAN WART: The hospital year and
5 the provincial year do not end on the same days?

6 MR. ROSS: The hospital year is a calendar
7 year; the provincial fiscal year ends on the 31st of
8 March.

9 THE CHAIRMAN: But the operating year under
10 the Dominion Provincial Agreement is the calendar year,
11 as I understand it?

12 MR. ROSS: I believe that it is, sir.

13 THE CHAIRMAN: Now, those hospitals that have
14 a municipal base have the right to ask for as much ad-
15 ditional monies as may be required to balance the budget,
16 as I understand it. It is the voluntary hospital without
17 any place to go for taxes that faces getting the money
18 wherever it can find it?

19 SISTER MARY: That is true.

20 MR. ROSS: I might point out in the City of
21 Calgary the City Council on its own has undertaken to
22 treat one of the large voluntary hospitals in the city on
23 the same basis as it treats its own general hospital and
24 is picking up at least most of or all of --

25 DR. GOGAN: All of. The City of Calgary has
26 taken a very enlightened view of the operations of the
27 Holy Cross Hospital. We have a special arrangement with
28 the provincial government who recognize the serious bed
29 shortage in the City of Calgary and until such time as
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8 stantially financially because of the much larger defi-
9 cit of their own hospital. They have been enlightened
10 enough to pick up the complete deficit during 1959 and
11 1960 and I believe they intend to do so for 1961.

12 THE CHAIRMAN: What will happen when the
13 Foothills Hospital is in operation?

14 DR. GOGAN: We will be back with the gang.

15 THE CHAIRMAN: Was that the only special
16 arrangement with the municipalities in the province that
17 you know of?

18 DR. GOGAN: To my knowledge, yes.

19 THE CHAIRMAN: Well, how do these deficits
20 arise?

21 DR. GOGAN: The provincial plan was based
22 on the operating costs in 1957 and following percentages
23 have been added to the provincial payment during suc-
24 cessive years. These payments range from 6 percent --
25 8 percent in the first year of operation, 6 percent in
26 the second year of operation and in 1961 3 percent.
27 However, a number of changes have occurred in the
28 hospitals. For instance, many of the hospitals now have
29 a 40-hour week for their student nurses and this has re-
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10 that the turnover in the lower paid echelons of the
11 hospital field has been one of the most grave problems
12 in producing --

13 THE CHAIRMAN: Known as the revolving door.

14 DR. GOGAN: Yes, and the fact that we have
15 achieved in many of our institutions a much greater de-
16 gree of stability in our staff as a result of competitive
17 wages, wages competitive with industry or almost has also
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20 they never had to pay. I would say those are the princi-
21 pal ones but there are others.

22 THE CHAIRMAN: Well, by the formula that was
23 devised a rated bed payment was arrived at, and I under-
24 stand that that is paid, to the hospitals on the rated
25 bed capacity of the hospitals. Is that the place from
26 which we start?

27 DR. WALLACE: Yes, sir.

28 THE CHAIRMAN: Now, is there a difference
29 between the rated bed capacity and the actual number of
30 beds, the bed complement in all hospitals?

DR. WALLACE: Not all hospitals but many
hospitals during peak seasons do have. An extreme

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9 point that was brought out the other day by Dr. MacDonald
10 in which he said he liked to get the patient out of the
11 emergency into the hospital because they are not paid for
these patients.

12 COMMISSIONER BALTZAN: Where do they put these
13 extra 30 patients you were referring to?

14 DR. WALLACE: In this particular hospital in
15 corridors and the beds crowded together in wards and the
16 sunporches are used, areas that should normally be used
for up-patient areas.

17 THE CHAIRMAN: Then what happens at this
18 particular hospital in the way of payment at the end of
19 the year, what is the basis of payment?

20 DR. WALLACE: They are paid on the rated bed
21 capacity, sir.

22 THE CHAIRMAN: They get paid for housing 50
23 patients whereas they house 80 at one given time.

24 DR. WALLACE: Yes, sir. I believe the origi-
25 nal intent behind the rated bed capacity system, as I
26 understand it, was to discourage hospitals from setting
27 up extra beds, and thus cutting down on the minimum space
28 standards required. It is very difficult to do if the
29 hospital is not sized adequately to meet the needs of the
30 community.



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4 pression all hospital schools of nursing are on 40-hour
5 week. That is not so. There are a number who are still
6 on the 44-hour week. However, there have been serious
7 changes in the curriculum of the student nurses' standards,
8 and I use the word hesitantly, imposed upon it by the
9 University of Alberta which established its curriculum
10 without reference to the administrators of hospitals.

11 MR. ROSS: In this over-occupancy situation,
12 sir, there is the other factor of co-insurance. If the
13 co-insurance payments by the patients were, in fact, suf-
14 ficient to meet the added costs of keeping the bed oc-
15 cupied as opposed to keeping the bed empty then the
16 hospital with 80 patients in the 50 bed rated capacity
17 would be collecting co-insurance from the 80 patients,
18 although there would be basic payment on the basis of
19 this 50 beds. In theory the co-insurance, the actual
20 figure, the actual cost is a variable cost as opposed to
21 empty beds.

22 If the co-insurance is insufficient, of course,
23 the hospital suffers financially.

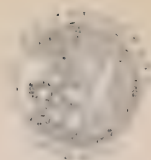
24 THE CHAIRMAN: The co-insurance is the \$2.00
25 or \$1.50.

26 DR. ROSS: \$1.50.

27 THE CHAIRMAN: What is that co-insurance
28 intended to cover?

29 DR. ROSS: As we understand it, at the out-
30 set of the plan it was intended to cover all variable
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THE CHAIRMAN: What do you mean by that?



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pression all hospital schools of nursing are on 40-hour week. That is not so. There are a number who are still on the 44-hour week. However, there have been serious changes in the curriculum of the student nurses' standards and I use the word 'basically' imposed upon it by the University of Alberta which established its curriculum without reference to the administrators of hospitals.

Mr. ROSS: In this over-occupancy situation,

if there is the other factor of co-insurance. If the co-insurance payments by the patients were, in fact, sufficient to meet the added costs of keeping the bed occupied as opposed to keeping the bed empty then the hospital with 80 patients in the 50 bed rated capacity would be collecting co-insurance from the 80 patients, although there would be basic payment on the basis of this 50 beds. In theory the co-insurance, the actual figure, the actual cost is a variable cost as opposed to empty beds.

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3 DR. ROSS: Well, I don't pretend to be an
4 expert in this field.

5 THE CHAIRMAN: I want to get your views on
6 it.

7 MR. ROSS: The types of costs in hospital
8 were generally divided into two types, fixed costs,
9 costs that went on whether they had 50 patients or 30
10 patients. They had to have the same staff. They had to
11 heat the building, they had to do all kinds of various
12 things and the fixed occupancy could go up and down, but
13 this cost maintained. There was the other type of cost
14 that is described as variable, which depending on the
15 occupancy of beds, quantities of drugs and medical and
16 surgical supplies, the quantity of food purchased and
17 this type of thing. I think it was assumed at the
beginning...

18 THE CHAIRMAN: By whom?

19 MR. ROSS: By the people who developed the
20 plan, the committee which developed the plan. As I
21 understand it the thought was that co-insurance would
22 cover the variable cost and the basic payment would cover
the fixed cost.

23 THE CHAIRMAN: In fact, has it worked out that
24 way?

25 MR. ROSS: Well, I think the suggestion that
26 the province itself made in its submission was that
27 probably the amount of the co-insurance had been in-
28 sufficient to cover the variable costs, and we believe
29 that it is insufficient to cover the variable costs.
30 Dr. Gogan could answer on this.



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DR. ROSS: Well, I don't pretend to be an

expert in this field.

THE CHAIRMAN: I want to get your views on

it.

MR. ROSS: The types of costs in hospital

were generally divided into two types, fixed costs,

costs that went on whether they had 50 patients or 30

patients. They had to have the same staff. They had to

heat the building, they had to do all kinds of various

things and the fixed occupancy could go up and down, but

this cost maintained. There was the other type of cost

that is described as variable, which depending on the

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3 THE CHAIRMAN: You are on the basis of the
4 two dollars?

5 DR. GOGAN: We are on the basis of \$2.00. A
6 very readily understandable variable is drugs and medical
7 and surgical supplies which cost approximately \$2.00 on
8 their own, without any further things.

9 THE CHAIRMAN: That is \$2.00 per patient per
10 day.

11 DR. GOGAN: That is right, sir.

12 THE CHAIRMAN: The other variables?

13 DR. GOGAN: The other variables would be the
14 cost of putting laundry through a laundry, use of house-
15 keeping supplies, linens etc., many others -- food. Food
16 would be recognized as a variable and the cost of that
17 in our institution is approximately 69 cents a patient
18 a day.

19 THE CHAIRMAN: What is the solution?

20 DR. GOGAN: The solution is a realistic ap-
21 proach to the actual expenses of operating. I feel the
22 establishment of certain standards, perhaps by a Board of
23 public health, but in consultation with people who know
24 something about hospitals.

25 THE CHAIRMAN: To achieve what, sir? What
26 would be the objective?

27 DR. GOGAN: If the Alberta government de-
28 cided to carry on its existing plan I would suggest if
29 they established the co-insurance to actually cover vari-
30 ables, the variables should be established by a cost
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3 total revenues of the hospitals vary. The expenses of
4 the hospital should be brought closer to their actual
5 expenses.

6 THE CHAIRMAN: Are you trying to say the
7 hospitals should be dealt with on an individual basis,
8 on a budget for each hospital dealing with the actualities
9 of the situation as they exist from year to year?

10 DR. GOGAN: There is a considerable allergy
11 to the use of the budget system. I am trying to pro-
12 pose a system which would work in accordance with the
13 provincial thinking on budgets.

14 THE CHAIRMAN: Let us start at the top. You
15 say there is an allergy to budgets. Is that discernable
16 at the highest level? Does the government not operate on
17 a budget?

18 DR. GOGAN: I believe it does.

19 THE CHAIRMAN: So the allergy isn't in
20 government?

21 DR. GOGAN: The allergy is presumably in the
22 Department of Public Health, sir. The use of the budget
23 system is, as you are probably aware, isn't the panacea
24 either. In other words a budget can be quite unrealistic
25 by controlled rate boards. Therefore you must have an
26 additional mechanism to the budget system and the one
27 Dr. Wallace suggested in his opening remarks of some form
28 of appeal board which could take a realistic look at
29 both the Department of Public Health's point of view and
30 the hospitals' point of view seems to me to be the most
equitable answer to this situation.

THE CHAIRMAN: Dr. Gogan, you had experience
with the inauguration of the hospital prepayment system

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THE CHAIRMAN: Dr. Cogan, you had experience with the inauguration of the hospital payment system



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3 in Saskatchewan before the Dominion Government became a
4 partner in the payments.

5 DR. GOGAN: Not with the inauguration, from
6 1951, approximately.

7 THE CHAIRMAN: At that time we had abandoned
8 the point system of payment. We had adopted the budget
9 system. Was some appeal provision provided there to
10 appeal from the rate board by the hospital.

11 DR. GOGAN: There was no formal appeal pro-
12 vision, sir, but in practise if the rate board decision
13 wasn't accepted by the hospital they, in many cases,
14 could continue and did continue to the Deputy Minister
15 as an individual, and from him to the Minister, and if
16 they weren't satisfied there they could appeal to the
17 Cabinet. Now, this did occur. One of my first tasks
18 in that particular position was to resolve a deficit of
19 some three years' duration in the City Hospital in
20 Saskatoon, something in the region of \$400,000.

21 THE CHAIRMAN: Is there an organization such
22 as the Rate Board in Alberta, the equivalent to the Rate
23 Board?

24 DR. GOGAN: Not that I am aware of, sir.
25 There is, I believe, a committee of departmental officials
26 which calls itself the Rate Board, but it doesn't function
27 in the same meticulous manner as the Rate Board did in
28 Saskatchewan. Once the ceiling is fixed we feel there is
29 virtually little or no appeal against it. I believe the
30 Holy Cross Hospital in the City of Calgary did appeal
against it because of the shortage of beds in Saskatoon.

THE CHAIRMAN: Calgary.



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3 DR. GOGAN: Calgary, and succeeded in having
4 one-third of our deficit met. I think there is some
5 method of appeal. It is very complex.

6 THE CHAIRMAN: Well now, we move into the
7 area in which the Federal Government may be more inti-
8 mately concerned. We have Hospital A, let us assume,
9 that the actual operating cost of the hospital is, say,
10 \$1,100,000, and just for discussion purposes the amount
11 payable, under the rated bed day, with ad-
12 justments, comes to \$1,000,000, so that we have a deficit
13 of \$100,000.

14 When the Government of Alberta submits its
15 account to the Government of Canada to recover the
16 47, 48 or 49 percent, whatever it might be of the oper-
17 ating costs under the established formula, do you know
18 whether the Government puts in the actual figure of
19 \$1,100,000, which is the actual operating expense or
20 the \$1,000,000 which is the amount that the Government
21 has recognized that the hospital will get.

22 MR. ROSS: Mr. Chairman, I believe, although
23 obviously we do not make these claims, the Provincial
24 Government makes them, but I believe they claim on the
25 basis, reimbursed basis on what they actually pay. If
26 you want a precise answer to that question Mr. Campbell
27 is here.

28 THE CHAIRMAN: I noticed Mr. Campbell is
29 here.

30 MR. ROSS: Mr. Campbell could give that in-
formation more accurately than we could.

THE CHAIRMAN: Would you like to come up here?



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DR. GOGAN: Calgary, and succeeded in having one-third of our deficit met. I think there is some method of appeal. It is very complex.

THE CHAIRMAN: Well now, we move into the area in which the Federal Government may be more intimately concerned. We have Hospital A, let us assume, that the actual operating cost of the hospital is, say, \$1,100,000, and just for discussion purposes the amount payable, under the rated bed day, with adjustments, comes to \$1,000,000, so that we have a deficit of \$100,000.

When the Government of Alberta submits its account to the Government of Canada to recover the \$7, 48 or 49 percent, whatever it might be of the operating costs under the actualized formula, do you know whether the Government puts in the actual figure of \$1,100,000, which is the actual operating expense or the \$1,000,000 which is the amount that the Government has recognized that the hospital will get.

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MR. ROSS: Mr. Campbell could give that information more accurately than we could.

THE CHAIRMAN: Would you like to come up here



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3 There is a chair.

4 MR. CAMPBELL: I will stay where I am, thank
5 you. The basis of the payment is based on the actual pay-
6 ment which is made by the Provincial Government. The
7 municipal account is an arm that the Provincial Govern-
8 ment is being tied with at the present time. From the
9 standpoint of the possibility that certain of these, so-
10 called, excess costs might be -- at the present time so
11 far as the claim that the Provincial Government makes
12 against the Federal Government in making their claim in
13 the joint programme, it is the actual amounts which are
14 paid by the Provincial Government, which in this case
would be \$1,000,000.

15 THE CHAIRMAN: Now, have you any reason to
16 believe, Mr. Campbell, that the Dominion Government costs,
17 the Department of Health would have any objection to
18 paying, to dividing the costs under the established
19 formula on the basis of the actual operating expenses of
the hospitals in Alberta?

20 MR CAMPBELL: This raises the whole question
21 we have discussed, and there are differences of opinion
22 which exist. Statistics are provided which indicate a
23 particular situation. I am sure that the Alberta
24 Hospital Association did not wish by any implication to
25 indicate that any hospital operating within the ceiling
26 is not providing a good and reasonable standard of care.
27 There are a number in that category. This raises the
28 basic question of whether or not the ceilings which have
29 been set for the individual hospitals are, in our opinion,
adequate.
30

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THE CHAIRMAN: Now, have you any reason to believe, Mr. Campbell, that the Dominion Government costs, the Department of Health would have any objection to paying, to dividing the costs under the established formula on the basis of the actual operating expenses of the hospitals in Alberta?

MR CAMPBELL: This raises the whole question we have discussed, and there are differences of opinion which exist. Statistics are provided which indicate a particular situation. I am sure that the Alberta Hospital Association did not wish by any implication to indicate that any hospital operating within the ceiling is not providing a good and reasonable standard of care. There are a number in that category. This raises the basic question of whether or not the ceilings which have been set for the individual hospitals are, in our opinion,



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3 THE CHAIRMAN: Are in whose?

4 MR. CAMPBELL: The province.

5 THE CHAIRMAN: The province being represented
6 by whom?

7 MR. CAMPBELL: By the Department of Health,
8 the Minister of Health together with consultation with
9 the Alberta Hospital Association, the Medical Association
10 and the Nursing Association, all those who are concerned
11 with it. We would have differences of opinion in regard
12 to this, as you will perhaps realize from the information
13 you have just been given, but basically our principle
14 is that the cost level which has been set up is adequate
15 to provide a reasonable level of care and I think in the
16 Province of Alberta that is being done irrespective of
17 the ceiling.

18 THE CHAIRMAN: By that you mean that the
19 hospital -- there are 92 hospitals giving Cadillac ser-
20 vice to the extent of \$2,725,000 above the judgment of
21 the Department.

22 MR. CAMPBELL: That statement has been made,
23 but again it is, as I say, it is questionable.

24 THE CHAIRMAN: I don't want to go off into
25 a sideline at the moment. I am not going to preclude
26 you from making any explanation you may feel you desire
27 to make, but I would like to pursue this idea of re-
28 covery of the share of the operating cost of the hospitals
29 in Alberta from the Federal Government. In the Act under
30 which the costs are shared is the expression operating
expenses, actual operating expenses?

MR. CAMPBELL: Paid.



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3 THE CHAIRMAN: Excluding -- paid, that is
4 paid by the hospital.

5 MR. CAMPBELL: No, by the province.

6 THE CHAIRMAN: So that by some process if
7 you decide to drop the rated bed business to \$7.00 a day
8 you could take \$2.50 away from the hospital.

9 MR. CAMPBELL: That is right. That is the
10 same situation that exists in regard to co-insurance as
11 was pointed out on Monday. The province is not from the
12 standpoint of policy, and the general policy -- I don't
13 want to make any statements in regard to general policy.
14 Any statements I make are merely my interpretation in
15 view of having worked with the Provincial Government, my
16 interpretation of what those policies are. Basically the
17 policy has been, in regard to ceiling control and if this
18 means that there is an impass which we would otherwise
19 be able to collect from the Federal Government, it is
20 part of our responsibility as partners in this control of
21 costs.

22 THE CHAIRMAN: By accelerating this downward
23 you may force the voluntary hospitals into liquidation
24 and out of business.

25 MR. CAMPBELL: That is not...

26 THE CHAIRMAN: That could be the result.

27 MR. CAMPBELL: I would only make the statement
28 in regard to this, I don't think that this is the intent
29 and I don't...

30 THE CHAIRMAN: The road to hell was paved with
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MR. CAMPBELL: The result, I think, is not

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5 and we have attempted to meet them. As government some-
6 times moves more slowly than business this all takes
7 some time, but I don't think that lag will result in
8 what you have indicated as a possibility.

9 THE CHAIRMAN: Now then, Mr. Campbell, where
10 will the voluntary hospitals get the money to pick up
11 the deficits?

12 MR. CAMPBELL: You had Dr. Ross here on
13 Monday. You asked him a specific statement. He didn't
14 actually hedge. He indicated to you that the avenue
15 was being opened for this particular purpose, and that
16 I believe, had not been previously opened. It had
17 certain features attached to it which prevented, as
18 Sister Mary has indicated to you this morning, it pre-
19 vented them. On this I hesitate to say more than what
20 Dr. Ross has said. I think he left you with the impli-
21 cation. In this particular area, since this legislation
22 which has not yet been put through, I think you
23 appreciate well I have my particular position in this
24 regard.

25 THE CHAIRMAN: I think that is fair enough,
26 but even with the legislation, if you eliminate the
27 last two sub-sections of Section 11, the hospital has
28 still got to find a municipality that is going
29 to enter into an agreement. That is the effect, isn't
30 it?

MR. CAMPBELL: I think it is, yes.

CHIEF JUDGE BUCHANAN: I think it is, sir.

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CHIEF JUDGE RICHMAN: I think it is, sir.



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4 THE CHAIRMAN: Purely presumptive.

5 THE CHAIRMAN: That is it.

6 THE CHAIRMAN: If they cannot find that type
7 of generosity in the municipality, then the only place
8 else is the resources of the community; of the religious
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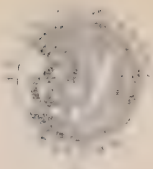
9 MR. CAMPBELL: I would like to, once again,
10 follow the statement which I had made, that if the
11 ceiling which has been set is adequate to provide a
12 reasonable degree of care, then there should not be any
13 excess cost, and to promote having somebody meet these
14 excess costs, if they do lie in the area of inefficiency,
15 would be defeating your purposes of control. If the
16 excess costs are not in that particular area, then this
17 is an area which the Provincial Government should look
18 at very closely from the standpoint of the possibility of
19 picking up those costs which have been labelled as ex-
cess costs which are not logically of that type.

20 THE CHAIRMAN: Who makes that decision? I
21 mean, is it you, Mr. Campbell? I think that is the issue
22 we are coming to.

23 Has a beaurocracy been set up under
24 which the hospitals are under the thumb of one man?

25 MR. CAMPBELL: I would hesitate to answer
26 that particular question. The answer that I would
27 logically make is no, but as I say there may be dif-
28 ferences of opinion in respect to that, depending upon
29 the position of the individual concerned in relation
30 to what is being dealt with.

COMMISSIONER BALTZAN: Reverend Sister, and



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COMMISSIONER BARTON: Reverend Sister, and



gentlemen, I want to begin by saying that your submission contains some very illuminating observations, and I will confine myself to those things which are very illuminating.

Now, we turn to page 8 of Section 1, and I will read:

"It is also interesting to note that the number of births in hospitals in Alberta was amongst the highest in Canada per capita and that maternal death rates and infant death rates was amongst the lowest in Canada."

The point is that you have been admitting more people, more women for their obstetrical needs than perhaps in other areas or in other provinces?

DR. WALLACE: That is true.

COMMISSIONER BALTZAN: And, by the same token, you prove that your maternal and infant mortality was reduced.

The question, no. 1, and these are not loaded at all, because I am as much concerned as most of you: What was your average day stay for obstetrical care?

DR. WALLACE: I would say, sir, in Alberta the average stay for obstetrical cases is in the vicinity of 7 days.

COMMISSIONER BALTZAN: And how does that compare with what you have learned in other public health departments in other provinces?

DR. WALLACE: This, sir, is longer than most other provinces, and I did, following our talk about this



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3 problem the other day, discuss the matter with the
4 professor of obstetrics and gynecology at the University,
5 and as well looked up some statistics. Dr. Vant, who
6 stated he may be quoted on this, also stated this is the
7 agreed opinion of other professors of obstetrics and
8 gynecology, and other specialists across the Country.
9 He indicated that in his opinion the minimum stay of a
10 woman after having her baby is 7 days. He feels this is
11 so, to give her a chance to rest so that she could, if
12 she wished, nurse the baby, and could return to her home
responsibilities in reasonably good health.

13 The statistics that we were given the
14 other day regarding Newfoundland, I believe, points the
15 matter up.

16 In 1959, the maternal mortality in
17 Canada averaged .5 per thousand.

18 THE CHAIRMAN: 1959?

19 DR. WALLACE: 1959, sir, yes.

20 In Alberta, it was .4 per thousand,
21 and in Newfoundland, .8 per thousand.

22 THE CHAIRMAN: You go back ten years, and it
23 was -- the graph went straight up?

24 DR. WALLACE: Yes, infant mortality in 1959,
25 Canada average, 28 per thousand; Alberta, 24 per thou-
26 sand; Newfoundland, 39 per thousand.

27 The professor of obstetrics and gynecology took this as an indication that the short stay
28 was not beneficial to the patient, and felt very strongly
that 7 days should be a proper length of time.

29 COMMISSIONER BALTZAN: In other words, to
30

problem the other day, discuss the matter with the
professor of obstetrics and gynecology at the University,
and as well looked up some statistics. Dr. Vent, who
stated he may be quoted on this, also stated that is the
agreed opinion of other professors of obstetrics and
gynecology, and other specialists across the country.
He indicated that in his opinion the minimum stay of a
woman after having her baby is 7 days. He feels this is
so, to give her a chance to rest so that she could, if
she wished, nurse the baby, and could return to her home
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The statistics that we were given the
other day regarding Newfoundland, I believe, points the
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Canada averaged .5 per thousand.

DR. WALLACE: 1959, sir, yes.

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and in Newfoundland, .5 per thousand.

THE CHAIRMAN: You go back ten years, and it
was -- the graph went straight up?

DR. WALLACE: Yes, infant mortality in 1959,
Canada averaged .38 per thousand; Alberta, .34 per thou-
sand; Newfoundland, .39 per thousand.

The professor of obstetrics and gynec-

ology took this as an indication that the short stay
was not beneficial to the patient, and felt very strongly
that 7 days should be a proper length of time.

COMMISSIONER WALLACE: In other words, to



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3 save a day would certainly not help to keep death away?

4 DR. WALLACE: Right, sir.

5 COMMISSIONER BALTZAN: May I pursue this a
6 little bit?

7 Would this half a day longer be called over-
8 utilization, or would these numbers of admissions per
9 population of those people who require the obstetrical
10 service be called over-utilization?

11 The thing that we have been confronted in
12 the estimates of costs and reductions and excess usage
13 of beds, would it be called over-utilization?

14 DR. WALLACE: No, sir. In this province,
15 it would not be called over-utilization.

16 COMMISSIONER BALTZAN: Would you term it
17 modern utilization?

18 DR. WALLACE: Modern utilization and good
19 patient care, sir.

20 COMMISSIONER BALTZAN: Would doctors be
21 ready to discourage patients from going into hospital for
22 this service?

23 DR. WALLACE: No, sir, we have been en-
24 couraging them to go in for this service.

25 COMMISSIONER BALTZAN: Thank you.

26 You see, I am directing these things in order
27 to throw a kind of proper light we want to have in all
28 aspects. Really, as we have gone through the Country,
29 we have found that there is a considerable amount of
30 conflict between the human and the dollar interests. It
is on that basis that I am trying to elicit your answers.

May I turn now to page 9 of Section 1, and



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3 I will read only in part, the second last paragraph:

4 "Another important force influencing the
5 increasing cost of hospital utilization care is that
6 of the dramatically improved income of the general
7 population and of the province."

8 I say to you, as I read it, that this is a
9 very courageous statement and very valuable because you
10 are facing reality. That is apparently a factor, or you
11 would not have put it down?

12 DR. WALLACE: Right, sir.

13 COMMISSIONER BALTZAN: It is not the demand;
14 it is a way of life, according to our means and where
15 the means are greatest, that sort of advantage people
16 want?

17 DR. WALLACE: Right, sir.

18 COMMISSIONER BALTZAN: In order to do this
19 saving of a day, would you work against this trend on
20 the part of people who feel that this is their way of
21 life, without again trying to save the day?

22 DR. WALLACE: Yes, sir, I think you have to
23 apply some resistance to this trend, otherwise you would
24 have uncontrollable utilization.

25 COMMISSIONER BALTZAN: Exactly.

26 But, on the other hand, as you have stated,
27 because of this circumstance which nobody else has yet
28 spoken of or have not dared to mention, as a fact of life
29 this controls or helps to interfere with your saving
30 principle of days in hospitals and costs?

DR. WALLACE: Right, sir.

COMMISSIONER BALTZAN: And you cannot help



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that?

DR. WALLACE: No.

COMMISSIONER BALTZAN: And you would not rule against it, or would you?

DR. WALLACE: No, sir. We would resist the over-utilization because of this tendency.

COMMISSIONER BALTZAN: But, so long as it is based on this principle of demand, and it is not over-done, and does not bring the costs out of range unnecessarily, that this is a contributory factor which is realistic, and you recognize it?

DR. WALLACE: Right, sir.

COMMISSIONER BALTZAN: So that it is not administrators that are always at fault, and it is not the medical staffs that are always at fault, and it is not even the public that is always at fault. It is the dollar, perhaps, that is at fault.

I refer you to page 13, and I think it is in Section 3.

DR. WALLACE: It is No. 3, sir.

COMMISSIONER BALTZAN: Do you follow me?

DR. WALLACE: Right.

COMMISSIONER BALTZAN: And I certainly follow you, Dr. Wallace.

DR. WALLACE: Thank you, sir.

COMMISSIONER BALTZAN: The last portion of the last paragraph:

"The increasing utilization of hospital services lead us to conclude that hospital operating costs may be expected to continue to increase at the rate of 5 percent to 8 percent per annum for an indefinite



DR. WALLACE: No.

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DR. WALLACE: Thank you, sir.

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the last paragraph:

"The increasing utilization of hospital ser-

may be expected to continue to increase at the rate of

5 percent to 8 percent per annum for an indefinite



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3 period of time."

4 I think just the other day we concurred with
5 statistics elsewhere that over the last ten years these
6 costs have increased at the rate of 5 percent?

7 DR. WALLACE: Right.

8 COMMISSIONER BALTZAN: And there is no stop-
9 ping it?

10 DR. WALLACE: Right, sir. These trends, sir,
11 would be indicated by the statistics published both by
12 the Dominion Bureau of Statistics on Hospital Care, and
13 by the United States Public Health Service.

14 COMMISSIONER BALTZAN: And this increase is
15 not due to somebody making more money out of the deal?

16 DR. WALLACE: Certainly not.

17 COMMISSIONER BALTZAN: This is due to the
18 fact that you have to pay higher wages. I think you have
19 outlined that?

20 DR. WALLACE: Right, sir.

21 COMMISSIONER BALTZAN: So, the increase in
22 costs of hospital services is because you yourself have
23 to pay more in order to get them?

24 DR. WALLACE: Right, sir.

25 COMMISSIONER BALTZAN: Then, as things have
26 proceeded in the last little while, if I am correct in
27 that assumption, those who budget for you estimate your
28 amounts for the next year on the basis of last year?

29 DR. WALLACE: Right.

30 COMMISSIONER BALTZAN: So that at the end
of that time you are really two years behind?

DR. WALLACE: Right.



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DR. WALLACE: Right.



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3 COMMISSIONER BALTZAN: My mathematics is
4 improving!

5 DR. WALLACE: Very good, sir. I wonder, sir,
6 if I might add some information?

7 COMMISSIONER BALTZAN: Please do.

8 DR. WALLACE: In the Annual Report of the
9 Hospitals Division of the Department of Public Health,
10 1960, page 45, Table 25, it indicated the increase in
11 gross expenditures in general hospitals from the years
12 1950 to 1960. If I may just quickly go through them.
13 It is on page 8, towards the end, Roman numeral 8, I
14 believe someone was using the other day. It is right
15 near the end of the brief.

16 The percentage yearly increase goes through
17 13.5 percent, 14.1 percent, 21.9 percent, 14.7 percent,
18 8.6 percent, 10 percent, 12 percent, 10 percent, 16 per-
19 cent, and 9 percent through the successive years.

20 Most of these years were before hospitali-
21 zation plans were in effect across the Country, and
22 actually the percentage increases were basically larger
23 before the plan than they have been since.

24 COMMISSIONER BALTZAN: To conclude, Dr.
25 Wallace, thank you very much, could it be said that the
26 dollar unit must equal the quality unit?

27 DR. WALLACE: Yes, sir.

28 COMMISSIONER BALTZAN: Could it be said if
29 you save one you lose the other?

30 DR. WALLACE: Yes, sir.

COMMISSIONER BALTZAN: You are very agreeable.

DR. WALLACE: I am very agreeable this



COMMISSIONER BARTMAN: My question is

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DR. WALLACE: Very good, sir. I wonder, sir,

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COMMISSIONER BARTMAN: Please do.

DR. WALLACE: In the Annual Report of the Hospital Division of the Department of Public Health, 1960, page 45, Table 12, it indicated the increase in gross expenditures in general hospitals from the years 1950 to 1960. It may not quickly go through them. It is on page 8, towards the end, Table 12, I believe someone was using the other way. It is right near the end of the report.

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3 morning, sir. You are talking my language at the moment.

4 COMMISSIONER BALTZAN: Is this your language,
5 too, heads I win and tails you lose?

6 DR. WALLACE: Very good.

7 COMMISSIONER VAN WART: Mr. Chairman, Dr.
8 Vant's name has been mentioned with regard to discharges
9 from hospitals. In the course of his conversation did
10 he make any mention of re-admissions of obstetrical
11 cases following an early discharge? Whether they were
12 prevalent or not?

13 DR. WALLACE: He did not make any statement
14 of that sort, sir, but I believe it would be true from
15 our very few, what you might call early discharges in
16 the province -- perhaps Dr. Gogan could answer. Their
17 stay rate is, because of the pressure of beds, lower
18 than the rest of the province.

19 DR. GOGAN: I do not have exact statistics
20 for you on this particular point but the average length
21 of time for obstetrical cases in Calgary is approximately
22 a day less than in Edmonton, and I know that we did have
23 in our hospital a substantial number of re-admissions
24 with delayed hemorrhage, and that type of thing. There
25 were not a great number; we lost no lives as a result of
26 this, but certainly the number of patients did suffer
27 considerable personal inconvenience, to put it mildly.

28 I support what Dr. Wallace has said about a
29 minimum of 7 days being a realistic figure for an ob-
30 stetrical case in a hospital.

COMMISSIONER VAN WART: And in the early
discharges, did he mention subsequent re-admissions for



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COMMISSIONER VAN WART: And in the early

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4 gynecological conditions a few months after that he at-
tributed to early discharges?

5 DR. GOGAN: Yes, sir, he did indicate this,
6 sir, yes.

7 COMMISSIONER GIRARD: I direct this question
8 to either Dr. Wallace or Dr. Johnston or Dr. Gogan, any
9 of the hospital administrators, and it refers to Exhibit
10 127, the recommendations, Paragraph 6-1, on page 20,
11 Sub-paragraph C.

12 It reads that minimum standards of patient
13 care be developed by Federal and Provincial authorities
14 in consultation with the association representing hospi-
15 tal administration, the medical profession and the nurs-
ing profession.

16 What are the means that you intend to use to
17 develop this minimum standard of patient care?

18 DR. WALLACE: This statement was made on the
19 basis of a survey of smaller hospitals in the province
20 that had been done over the past two years in an effort
21 to decide what standard of care was being provided to
patients.

22 COMMISSIONER GIRARD: You mean the survey
23 has been done?

24 DR. WALLACE: The survey has been done, and
25 I believe the nursing care --

26 COMMISSIONER GIRARD: We are talking about the
27 nursing survey; the one spoken of yesterday?

28 DR. WALLACE: Yes, I believe it has been
29 taken in as an exhibit by this Commission, and that copies
30 of the report will be subsequently sent to you.

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3 COMMISSIONER GIRARD: Was this just a survey
4 of nursing care? Here you say minimum standards of
5 patient care but in minimum standards of patient care
6 do you mean just nursing care?

7 DR. WALLACE: It was really indicated patient
8 care by the nursing team so in effect it would include
9 the broad term of nursing care. It did not go into
10 para nursing fields in the hospital, it was strictly
11 bedside and total nursing care of the patient
12 so I believe the term nursing care would be quite ac-
13 ceptable in terms of reference of the study.

14 COMMISSIONER GIRARD: Now, this is to deter-
15 mine the minimum standards; does this mean that what will
16 happen to those standards which are above the minimum,
17 will they have to --

18 DR. WALLACE: No, ma'm.

19 COMMISSIONER GIRARD: Always keeping the
20 dollar in mind because that is important.

21 DR. WALLACE: I think this is a positive
22 approach, no approved hospital should provide less than
23 this type of service. In other words, this would be the
24 Dodge service that the Minister referred to in his brief.

25 COMMISSIONER GIRARD: Some are in the Fiat
26 category just now.

27 DR. WALLACE: Yes, we would prefer the Dodge
28 if we could with no attempt to advertise. The hope was
29 particularly in small hospitals. We felt at the start
30 of this study that large hospitals from their medical
superintendents and directors of nursing and the people
they have on their staff were able to maintain and to

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COMMISSIONER GILKIN: Now, this is to differentiate the minimum standards does this mean that what will happen to those standards which are above the minimum, will they have to --

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3 judge fairly exactly the quality of care that they are
4 providing, and, therefore, the study was devoted to
5 attempting to improve the quality of care; first, to
6 assess the quality of care and then to attempt to im-
7 prove it in the smaller hospitals in the province.

8 COMMISSIONER GIRARD: May I stop you there?
9 You said the directors of nursing were able to maintain
10 quality of care that they have been giving, is this ex-
11 act all through the hospitals where the quality of care
12 was quite a bit higher and are they still able to main-
tain that or is there a levelling off going on?

13 DR. GOGAN: I would suggest you ask Sister
14 Mary to comment on that because she has had the experi-
15 ence in her hospital which I think would interest you.

16 COMMISSIONER GIRARD: I do not want to enter
17 into the economics because we have experts that will do
18 that but this has a bearing on it. You cannot maintain
19 excellent care if, on the other hand, you do not get the
20 necessary material to do it with and that, of course, is
money.

21 SISTER MARY: May I say in that regard that
22 I administer a smaller hospital and we try to give the
23 best patient care we can. When we are faced with continu-
24 al deficit financing as in the past year we have to get
25 so close to the dollar, shall we say, with the areas of
patient care . . .

26 The actual experience of the past year, I tried
27 to preserve patient care intact, that is, good patient
28 care would be given. Throughout the areas that I curtailed
29 expenditures in to try to meet this dollar deadline,
30

judge fairly exactly the quality of care that they are providing, and, therefore, the study was devoted to attempting to improve the quality of care; that, to assess the quality of care and then to attempt to improve it in the smaller hospitals in the province.

COMMISSIONER GIBBARD: May I stop you there? You said the directors of nursing were able to maintain quality of care that they have been giving, is this exact all through the hospitals where the quality of care was quite a bit higher and are they still able to maintain that or is there a leveling off going on?

DR. GOSMAN: I would suggest you ask Sister Mary to comment on that because she has had the experience in her hospital which I think would interest you.

COMMISSIONER GIBBARD: I do not want to enter into the economics because we have experts that will do that but this has a bearing on it. You cannot maintain excellent care if, on the other hand, you do not get the necessary material to do it with and that, of course, is money.

SISTER MARY: May I say in that regard that I administer a smaller hospital and we try to give the best patient care we can. When we are faced with continuing deficit financing as in the past year we have to get so close to the dollar, shall we say, that the areas of

The actual experience of the past year, I tried to preserve patient care intact, that is, good but care would be given. Throughout the year that I am talking about, expenditures in to try to meet this dollar deadline



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3 were the fringe areas, maintenance, houskeeping,
4 that sort of thing; you cut down your maintenance work,
5 you curtail here and you curtail there and you try not to
6 curtail the basic heart of the hospital which is patient
7 care. However, eventually if we are faced continuously
8 with deficit financing we are going to encroach on this
9 particular area which is why our hospitals exist.

10 COMMISSIONER GIRARD: Would you agree if you
11 cut down your maintenance work too much you may have a
12 staph infection; what would this do to patient care?

13 SISTER MARY: Absolutely. We just cannot do
14 this, it is dangerous, even the fringe areas are danger-
15 ous to curtail to such an extent that we would have to
16 cut staff on maintenance or painting or something of
17 that sort.

18 COMMISSIONER GIRARD: When I said "staph" I
19 was talking in medical terms.

20 SISTER MARY: Yes, of course.

21 COMMISSIONER GIRARD: Dr. Wallace, we have
22 not seen this exhibit, it was filed with us but we did
23 not have a chance to read it. Does this go into the
24 number of personnel needed, the number of hours needed?
25 What does it go into? Can you give us some ideas of the
26 survey?

27 DR. WALLACE: The results go into minimum
28 numbers insofar as safety of patients and personnel does
29 not indicate this is the number that hospitals should
30 employ but they should not employ less than this number.
In any size of hospital it was agreed a minimal of five
registered nurses should be on staff to provide 24-hour



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3 coverage and there should be 24-hour on the floor cover-
4 age with a registered nurse in all hospitals. It further
5 went into the -- it studied the setting of hours of
6 nursing and that is the type of approach. It was de-
7 cided in any hospital, individual areas of the hospital,
8 because of their function, require different staffing
9 patterns and as a result of a study of this particular
10 phase the survey itself recognizes that this type of
11 yardstick not be used, that no minimum or no staffing
pattern was laid down to cover all hospitals, for instance.

12 COMMISSIONER GIRARD: This is a guide?

13 DR. WALLACE: It is a guide.

14 COMMISSIONER GIRARD: You cannot take it and
15 apply it directly to one hospital?

16 DR. WALLACE: No.

17 COMMISSIONER GIRARD: But you could use it
18 as a guide. How many hospitals participated in this
survey?

19 DR. WALLACE: There were approximately 70
20 hospitals surveyed by the actual surveying teams. The
21 teams were composed of registered nurses who visited the
22 hospitals and worked as members of the staff for varying
23 periods of time.

24 COMMISSIONER GIRARD: You said that hospital
25 administration and the medical profession took part in
26 this but how extensively were they involved in this
survey?

27 DR. WALLACE: The nursing care survey study,
28 the original committee to carry out this work was com-
29 posed of representatives of the Hospital Association,
30



coverage and there should be 24-hour on the floor coverage with a registered nurse in all hospitals. It further went into the -- it studied the setting of hours of nursing and that is the type of approach. It was included in any hospital, individual areas of the hospital, because of their function, requiring different staffing patterns and as a result of a study of this particular phase the survey itself recognizes that this type of variation not be used, that no minimum or no staffing pattern was laid down to cover all hospitals, for instance.

COMMISSIONER GIBBARD: This is a matter?

COMMISSIONER GIBBARD: You cannot take it and

apply it directly to one hospital?

DR. WALLACE: No.

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3 the Medical Association, the Alberta Association of
4 Registered Nurses and the Government so it was a combined
5 effort of the four groups.

6 COMMISSIONER GIRARD: So this would be to the
7 satisfaction of all these groups?

8 DR. WALLACE: Right.

9 COMMISSIONER GIRARD: On the following page
10 at the end of Paragraph 4, the last line says:

11 "It follows that if the primary function
12 of caring for the sick is to be adequately performed
13 educational activities must be entered into to a
14 greater or smaller degree."

15 It is the last two words that worry me. I
16 would hate to see it a smaller degree but the word is
17 there.

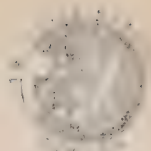
18 DR. WALLACE: I would presume that it should
19 be "rather" in there.

20 MR. ROSS: It is on Appendix I, the first
21 page?

22 DR. WALLACE: This particular brief was not
23 prepared by this committee, it was prepared by another
24 committee and I am afraid I cannot be of assistance.

25 DR. GOGAN: I would say this would apply to
26 the amount of time available in a small hospital for in-
27 service education and training as compared to the function
28 which a large hospital should carry out.

29 COMMISSIONER GIRARD: It should be related
30 to the functions of the hospital, if it is a large
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3 degree.

4 DR. GOGAN: We would feel there is a need for
5 in-hospital training regardless.

6 COMMISSIONER GIRARD: Thank you very much.

7 THE CHAIRMAN: Mr. Campbell, if I may, I
8 would like to go back to a reference --

9 MR. CAMPBELL: Mr. Chairman, I would like to
10 indicate at this particular time that we have no hesi-
11 tancy whatever in co-operating and in giving to you any
12 information that we can provide. This is the attitude
13 which we have adopted in regard to all related groups
14 that have been appearing before you. But, inasmuch as
15 the presentation was made by the province and you did
16 ask me to come down this morning and I did come down with
17 the idea if I could give any information such as has been
18 asked so far that I would be quite willing to do so; I
19 leave it to your discretion from the standpoint if there
20 are certain questions that I can clarify I will be quite
21 willing to do that. You understand my particular situ-
22 ation and I would be pleased to answer any questions
23 which you may choose or if there are any questions you
24 choose to submit to us I would forward the answers to you.

25 THE CHAIRMAN: It was just in the reference
26 to the agreement between the province and the Dominion.
27 I have had made available the Hospital Insurance & Diag-
28 nostic Services Act to see if it could throw any light
29 on what should be the shared cost between the provinces
30 and the Dominion. I see in Section 2, Sub-section D:

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6 Rather than say "This amount a province
7 might choose to pay a hospital." I just wanted to draw
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9 agreement.

10 MR. CAMPBELL: May I enlarge on that from
11 the standpoint that the Federal Government naturally has
12 some control in regard to payments which they make; they
13 do not make a flat payment in regard to this. This con-
14 trol is exercised on the basis of the amount, they leave
15 the provincial jurisdiction to decide the level that
16 they will pay to the hospitals and it is on the basis of
17 the amount which is paid by the provincial government
18 that they will share.

19 THE CHAIRMAN: But what I am putting to you;
20 is there, do you sense any restriction in the Federal
21 legislation because if there is a deficiency there we
22 would want to know about it because we are trying to re-
23 view the situation in the light of improving existing
24 deficiencies.

25 MR. CAMPBELL: Nothing more than the
26 limitation.

27 THE CHAIRMAN: The limitations here appear
28 as exceptions to the exclusion of tuberculosis and mental
29 health.

30 MR. CAMPBELL: It is subject to review by
them on interpretation and so forth where we have some
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7 across Canada that they should be taken out. Now, should
8 something else be taken out if the result is the Dominion
9 Government is inhibiting the proper payment to the
10 hospitals of their actual cost of providing services in
11 the hospital. As the Act says, the Dominion Government
will share in paying.

12 MR. CAMPBELL: You recall on Monday when you
13 had the Hearing with the Department of Public Health it
14 was left that we were going to let you know, write to
15 you in regard to these particular areas.

16 THE CHAIRMAN: That is very good.

17 MR. CAMPBELL: Basically the Federal lay down
18 the area that they will cover and if the province in their
19 jurisdiction, if the province pays these excessive costs
20 and decides to raise the level then the Federal Govern-
21 ment will go along with it. There is no question about
it.

22 THE CHAIRMAN: Thank you very much.

23 MR. ROSS: There was one other area I am
24 surprised Mr. Campbell did not raise and that is the
25 question of co-insurance, the refusal of the Federal
Government to recognize co-insurance.

26 THE CHAIRMAN: That was stressed quite
27 strongly on Monday.

28 MR. ROSS: I think we subscribe to the pro-
29 vince's view on that.
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3 THE CHAIRMAN: That the Dominion Government
4 should share in the cost, the province is being dis-
5 criminated against. In terms of the other provinces we
6 heard that statement and understand it.

7 COMMISSIONER FIRESTONE: Dr. Wallace, if I
8 may turn to Paragraph A of your conclusions in the sup-
9 plementary submission and I quote:

10 "That government hospital insurance agencies
11 provide adequate funds to meet the operating costs
12 of approved hospitals."

13 We have heard quite a bit about some of the
14 difficulties of determining what are adequate funds. I
15 take it from what you were saying that your definition
16 of adequate funds would be funds required to meet the
17 total operating costs of the hospital?

18 DR. WALLACE: Right, sir.

19 COMMISSIONER FIRESTONE: Now, sir, apparently
20 in submitting your accounts to the province the province
21 may conclude that the costs to operate your hospital may
22 be somewhat less than your actual operating costs and
23 the problem then resolves itself to decide what are
24 reasonable operating costs required to maintain what you
25 describe as minimum or desirable standard of medical
26 care to provide adequate funds. The question that con-
27 cerns us is how one can arrive at such an assessment of
28 what are reasonable operating costs. Should this be left
29 to the discretion of an administrator or a department
30 which says the reasonable operating costs are last year's
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3 and the hospital to arrive at a reasonable operating
4 cost figure? Your present system, as I understand it,
5 is taking last year's cost and adding a certain percent-
6 age to it?

7 DR. WALLACE: That is the system.

8 COMMISSIONER FIRESTONE: We would like to
9 see an improvement of that system.

10 DR. WALLACE: Right, sir.

11 COMMISSIONER FIRESTONE: Could you offer this
12 Commission some advice as to the kinds of principle or
13 criteria that could be used to arrive at a more realistic
14 figure than the present system? Now, this is a difficult
15 question and please feel free to say that this matter of
16 principles, of criteria, has perhaps not been gone into
17 as adequately as you might wish to. If this is the case
18 the Commission would be quite happy if you and the other
19 members of your group would consider what would be a set
20 of criteria and how such a system could in fact operate
21 more effectively than the present system.

22 DR. WALLACE: I think we can give you a
23 better answer in that manner.

24 COMMISSIONER FIRESTONE: I understand you
25 will consider it and let us have your answer in writing?

26 DR. WALLACE: Right, sir.

27 COMMISSIONER FIRESTONE: If I might now turn
28 to Paragraph D of the same conclusions where you say:

29 "That effective means be developed by which
30 hospital performance can be evaluated on a more
practical basis than cost alone."

What other means do you have in mind?



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4 DR. WALLACE: If I may, Dr. Gogan has de-
5 veloped a very effective means and I would like him to
6 answer.

7 DR. GOGAN: You are probably aware of the
8 work which is carried out by the professional activities
9 study in Ann Arbor in Michigan involving the various
10 factors concerning patient care. A hospital has been
11 successful in developing a system in which we call auto-
12 matic index for medical evaluation which I shall refer
13 to as Aime which produces the same results virtually
14 using an accounting machine. Any accounting machine
15 which has a built-in memory can be used but in this
16 system we use a Burroughs sensomatic machine. National
cash have models which are suitable also and there are
other machines which are suitable.

17 I would be very happy to place
18 in the record a copy of my paper on the subject, and also
19 some examples of how the information can be analyzed,
20 for instance. I have available and I was going to present
21 this later, but this is perhaps suitable.

22 THE CHAIRMAN: This is a good time.

23 DR. GOGAN: This is a review of the work in
24 1961. It is rather a crude review. I haven't had the
25 opportunity to go into detail on it. It will give you
26 some idea of what we can do with these things. We can
27 analyze, for instance, taking the physician's point of
28 view -- we can do it from several angles. We can do it
29 by operative procedure. We can do it by diagnosis. We
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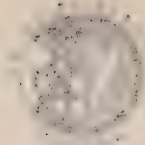
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analysis of four groups of doctors working in a hospital. The first group is the general practitioners, what we call the B privileges. This is the group of general practitioners who had prior to a certain date, and still continue to have full surgical privileges. The second group are the new general practitioners, who, I think, since 1953 have lesser surgical privileges. There is a group of interns and also a group of pediatricians. The pediatricians are somewhat loaded because we have included a number of new-born which should be excluded.

We know in our hospital, for instance, the laboratory utilization -- interesting things come from this. Both general practice groups use the laboratory on the average of 7.2 units, this is Dominion units of laboratory, 7.2 per admission. The average number of X-ray films is 1.3. The average length of stay, both these groups are identical, or virtually identical, 7.3 or 7.4. We have analyzed the number of emergency admissions, urgent admissions, and elective admissions and we note, it is rather interesting to compare the utilization of laboratory and X-ray by general practitioners with interns and we find that the internist group uses the laboratory to the extent of 25.7 units per admission as distinct from the general practitioner using it 7.2 or 7.3. They use our X-ray department 4.2 films of X-ray per admission as against 1.3 for the general practice group. There are drug costs. The drug costs in our study only include drugs not supplied on the floor, the more expensive type of drug that appear reasonable. It is interesting to note the difference between the general practitioners of



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\$2.47 and the internist of \$8.50. We can see where a hospital, perhaps, has a high proportion of admissions from specialists they might well justify a different economic approach. I can add to that; this rather startled me when I worked it out, the considerable number of surgical procedures associated with the admissions of internists. This may be due to the fact they belong to groups or some factor I cannot answer yet. The percentage of abnormal tissue removed at surgery in the internists' group through the surgical procedure for which, I presume they were indirectly responsible, was very much higher. In other words their performance in relation to diagnosis was very, very superior, which to me would justify at least to some extent the somewhat additional use they may make of our diagnosing facilities. This type of study, this is in its infancy, just one year old, we have a lot of bugs to tear out. This type of study can be done by a group of hospitals or by the government, although my personal feeling, which I would like to emphasize, if I may, it is a job for the College of Physicians and Surgeons of the Province to try and pull the medical profession much more closely into the actual business operation of medical economics.

COMMISSIONER FIRESTONE: This has been a most helpful explanation, sir.

COMMISSIONER BALTZAN: In connection with that, this has been most explanatory and very helpful, in connection with the usage of X-rays in laboratories in the amounts that you have stated, is not another factor that perhaps because these people, the specialists,



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5 DR. GOGAN: There is no question about that
6 at all. That is certainly true. That is one of the
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8 are interpreted properly by professional people who have
9 the type of background that you do, sir.

10 COMMISSIONER FIRESTONE: I understand from
11 what you are telling us, is that this new type of analysis
12 may turn out to be quite important in assessing utili-
13 zation of hospital facilities. I understand you have
14 prepared a paper on the subject?

15 DR. GOGAN: That is right.

16 COMMISSIONER FIRESTONE: Would it be possible
17 to obtain copies of this for the Commission and you could
18 add what additional notes you feel might help the Com-
19 mission to understand this type of system.

20 DR. GOGAN: With pleasure.

21 COMMISSIONER FIRESTONE: Thank you, sir. Dr.
22 Wallace, if I may now come to the brief which the Associ-
23 ated Hospitals of Alberta submitted to the Minister, Dr.
24 Ross, which you have included in Appendix II in our sub-
25 mission dated January 12th, 1962. I am referring to IV,
26 recommendations, page 15, paragraph 1.

27 DR. WALLACE: May I give this, sir, to some
28 of the accounting and financial people. Mr. Ross, would
29 you?

30 MR. ROSS: I am listening.

COMMISSIONER FIRESTONE: If I may just pose
this question to you, sir: The policy of establishing

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COMMISSIONER FIRESTONE: If I may just pose this question to you, sir: The policy of establishing



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3 an arbitrary maximum percentage increase which is not
4 based on actual experience should be abandoned. I wonder
5 whether you could explain to the Commission what you mean
6 by arbitrary?

7 MR. ROSS: The word arbitrary is used there
8 as opposed to the basis of establishing the figure, the
9 percentage increase figure which is based on the actual
10 operating cost trends of the hospitals in the province
11 as a whole, which has been the basis of establishing the
12 cost formula in previous years. That is when it was
13 initiated, the plan started in 1958 and based on 1957
14 cost figures when the final settlements were made rates
15 were established higher than the 1957 rates but the amount
16 of the increase which was allowed was judged ostensibly
17 and as far as we are aware, by the cost runs of the
18 hospital in the intervening year. This happened in suc-
19 ceeding years. From the \$10. basic rated bed day rate
20 established in 1957 we climbed to a maximum rated bed
21 day rate of \$12.72 in respect of the year 1960. This
22 didn't put all the hospitals into the ~~clear~~ by any means,
23 in all those years, but at least the cost formula was
24 related to the actual trend in hospital costs in the
25 province. Now, what we feel has occurred now in respect
26 to the year 1961 is that it has been announced in advance
27 what the percentage increase may be. It may be, in
28 general terms 3 percent. This has been reiterated by
29 the Department officials and by the Minister at various
30 times. It may be 3 percent. This we suggest is an
arbitrary set amount of increase that will be allowed
rather than an increase which has resulted as a result



an arbitrary maximum percentage increase which is not based on actual experience should be abandoned. I wonder whether you could explain to the Commission what you mean by arbitrary?

MR. ROSS: The word arbitrary is used there as opposed to the basis of establishing the figure, the percentage increase figure which is based on the actual operating cost trends of the hospitals in the province as a whole, which has been the basis of establishing the cost formula in previous years. That is when it was initiated, the plan started in 1958 and based on 1957 cost figures when the final settlements were made rates were established higher than the 1957 rates but the amount of the increase which was allowed was fixed ostensibly and as far as we are aware, by the cost runs of the hospital in the intervening year. This happened in succeeding years. From the \$10. basis used bed day rate established in 1957 we climbed to a maximum rate of \$12.72 in respect of the year 1960. This didn't put all the hospitals into the clear by any means in all those years, but at least the cost formula was related to the actual trend in hospital costs in the province. Now, what we feel has occurred now in respect to the year 1961 is that it has been announced in advance what the percentage increase may be. It may be, in general terms 3 percent. This has been reiterated by the Department officials and by the Minister at various times. It may be 3 percent. This we suggest is an arbitrary set amount of increase that will be allowed rather than an increase which has resulted as a result



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3 of cost trend experienced generally through the province
4 in the year.

5 COMMISSIONER FIRESTONE: Sir, if that had
6 been done for that year what percentage increase would
7 have resulted?

8 MR. ROSS: I cannot give you an accurate
9 figure, Professor Firestone.

10 COMMISSIONER FIRESTONE: Approximately.

11 MR. ROSS: I am not sure whether the
12 Department itself would yet be in a position to give you
13 that figure. I would suggest something slightly in ex-
cess of 6 percent.

14 COMMISSIONER FIRESTONE: You feel that past
15 cost trends are an adequate basis to set a target figure
16 for the coming year. Is that your view?

17 MR. ROSS: I don't know if I would say that.
18 I would say it has been a basis that has been used.

19 COMMISSIONER FIRESTONE: We are interested
20 in finding out what you would recommend, sir. There is
21 no need for you to answer the question. If you wish to
22 consider the question with your other associates later.
23 We are interested in considered views on how to come to
24 grips with the problem on a practical manner satisfactory
to you.

25 MR. ROSS: Perhaps, my hesitancy is because
26 of the fact I don't know that I can speak for all the
27 members of the group. I think you might get as many
28 answers to that as they are people at the table. My own
29 view is that the system which was adopted in the province
30 when developing this formula was reasonably good. I



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3 think it was good. Perhaps Dr. Gogan may have left you
4 with the impression that the allergy to budgets referred
5 to was something respecting the Department of Health alone.
6 There are a great many hospital folks in the province
7 who have developed a budget allergy also. I am one of
8 them. I think the system which was adopted in this pro-
9 vince of establishing a basis of payment for hospitals
10 and providing for the increase in operating costs from
11 year to year was a fairly good system. I think it was
12 at least as good as the system adopted in any other pro-
13 vince in Canada and in many instances it was superior, if
14 not superior to all of them. The problem as at the moment
15 is that it seems that the actual cost expense of the
16 hospital is no longer going to be the criterion upon which
17 the formula is based, but rather someone is going to pick
18 a figure out of the air such as 3 percent and say hospital
19 costs may go up 3 percent. We submit this is completely
20 unrealistic and not within the philosophy upon which the
21 plan was developed in the first instance.

22 COMMISSIONER FIRESTONE: Thank you. Have you
23 consulted the Department of Health as to how they arrived
24 at the 3 percent figure? Maybe they have actually looked
25 at the reasonable cost increase. How do you know they
26 haven't unless you have asked them?

27 MR. ROSS: Having seen the cost figures in
28 the hospitals one's mathematics would have to be very poor
29 indeed to come up with a 3 percent figure for the cost of
30 operating hospitals in the province in 1961, we do not
suggest for a moment that the Department of Public Health
are deficient in mathematics to that degree.



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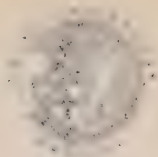


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3 COMMISSIONER FIRESTONE: It is no substitute
4 from consulting them and finding out what the actual
5 basis of their decision has been. Without trying to
6 suggest any manner in which you should handle your own
7 affairs, we are interested from the Commission point of
8 view in knowing whether there is an improvement of the
9 methods that have been in use.

10 MR. ROSS: In past years?

11 COMMISSIONER FIRESTONE: Or whether you are
12 suggesting to us you wish to revert to that use exactly
13 as it has been used in previous years.

14 MR. ROSS: There have been suggestions made
15 for improvement of the system in past years and there is
16 a suggestion here in this submission to the Minister of
17 Health to which you referred that the extent to which
18 services are provided in hospitals should be taken into
19 account in establishing the maximum rate that these
20 hospitals should receive, the ceiling, in other words.
21 That in the establishment of ceilings certain other factors
22 might well be considered. For example, we don't think
23 it is reasonable for hospitals like the University
24 Hospital, our largest hospital in the province with many
25 special services to have the same theoretical maximum as
26 a 25 or 35 bed hospital in a rural area which does not
27 have these services. In other words, there should be
28 some recognition given to dividing hospitals into groups
29 according to the types of services they render in
30 establishing the maximums. We also suggest that edu-
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COMMISSIONER FIRESTONE: It is no substitute

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3 hospitals, there should be greater recognition given to
4 the hospitals which provide these educational facilities
5 than was present in the past. We would suggest little
6 things, you might say, sir, that would improve the for-
7 mer system, but no great change. Actually, as far as I
8 am personally concerned that was a reasonably good ap-
9 proach that was taken in this Province.

10 COMMISSIONER FIRESTONE: I take it you have
11 given us some illustrations of what some of these little
12 changes may be, and there may be others and you may wish
13 to consult your associates. Would it be appropriate, Dr.
14 Wallace, that you include in a written submission a
15 more detailed outline of what that procedure should be,
16 in your considered opinion, that is yours and that of
your associates.

17 DR. WALLACE: Yes we will do this.

18 COMMISSIONER FIRESTONE: I come to Paragraph
19 2 on the same page in which there is reference, that a
20 higher maximum rated bed day cost be approved in cases
21 of the hospitals with a more extensive service. Have
22 you received any explanation from the Department of
23 Health as to why they don't acknowledge the increased
24 cost involved with respect to hospitals with more ex-
tensive service.

25 DR. WALLACE: I believe, sir, the theory is
26 that this has been included at the start of the plan and
27 that the larger hospitals at that time had more ex-
28 tensive services and that this trend would carry on. I
29 would suggest probably Mr. Sherwood who manages the
30 financial affairs of the University Hospital would be in



hospitals, there should be greater recognition given to the hospitals which provide these educational facilities than was present in the past. We would suggest little things, you might say, sir, that would improve the former system, but no great change. Actually, as far as I am personally concerned that was a reasonably good approach that was taken in this Province.

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3 a position to give details on that.

4 MR. SHERWOOD: I think, sir, Mr. Ross dealt
5 with this question in his explanation. The only thing I
6 could add at this time is that the plan does not seem to
7 provide for the progress or the advancing of a hospital
8 in the services that it is called upon to provide to the
9 community it serves. Advances are occurring in many
10 fields of medicine. Some of them are very expensive to
11 incorporate into a hospital. If the hospital is oper-
12 ating at its ceiling limit they are hard pressed to con-
13 sider incorporating these advantages into their programme.
14 Some of the advantages some of the larger hospitals don't
15 have, and should have I would think are things such as
16 physiotherapy departments, social service departments and
17 such. These have been mentioned previously, I am sure.
18 The hospitals find it difficult to incorporate these
19 into their ceilings that are fixed for them. They have
20 no way of establishing a higher ceiling so they can
21 progress.

22 COMMISSIONER FIRESTONE: Sir, you made a
23 good point in saying that any arrangement or system that
24 is developed should be flexible enough to take care of
25 progress, and the point you are making is that as
26 hospitals progress they will require additional facilities
27 to provide extended service. Dr. Wallace, would it
28 be possible in this submission, written submission to
29 provide us with a formula which would provide this, to
30 take care of the situation which has just been described
to us?

DR. WALLACE: I believe so, sir. I wouldn't



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DR. WALLACE: I believe so, sir. I wouldn't



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3 personally undertake to develop a formula. I am sure
4 the accounting people will be able to come up with one.

5 COMMISSIONER FIRESTONE: I take it this will
6 be a group effort.

7 DR. WALLACE: This will be a group effort.

8 COMMISSIONER FIRESTONE: Thank you very much,
9 sir. I come now to Appendix i which is attached to this
10 submission and it includes a letter addressed to various
11 hospitals, to the director of the Hospital Division,
dated September, 1961.

12 And there is in the last line or two a
13 reference, and I quote:

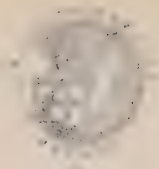
14 "To bring the budget into balance without
15 reducing patient care below an acceptable level."

16 The suggestion in this letter, as we under-
17 stand it, is advice to the hospitals and their admini-
18 strators to try and stay within the budget that has been
19 set for them, which is last year's costs, approved costs,
plus 3 percent. And there is this qualification:

20 "Without reducing patient care below an
21 acceptable level."

22 Now, what happens if the hospital that has
23 received this letter and has gone over its budget, and
24 it finds that it cannot live within the budget without
25 reducing patient care below what it considers an acces-
sible level? What happens then?

26 DR. WALLACE: The hospital continues to
27 provide care at an accessible level. The level of care
28 is not controlled in any way, I feel, by the admini-
29 stration of the hospital. It is the responsibility of
30



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the accounting people will be able to come up with one.
COMMISSIONER FISHBONE: I take it this will

be a great effort.

DR. WALLACE: This will be a great effort.
COMMISSIONER FISHBONE: Thank you very much.

Now, I come now to Appendix I which is attached to this
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3 the medical staff, and the medical staff committees, and
4 the nursing service throughout the hospital.

5 Therefore, the hospital normally would con-
6 tinue to provide the quality of service it considers to
7 be necessary for good patient care, and would hope that
8 at some subsequent time in the next year, after the
9 final decision has been made, that some means will be
10 found to regain the funds it has over-expended.

11 COMMISSIONER FIRESTONE: Would there be any
12 review by the Department of Health as to what the hospi-
13 tal has considered, and I quote: "an acceptable level
of patient care."

14 DR. WALLACE: No, sir, there would not under
15 the present organization.

16 COMMISSIONER FIRESTONE: And you are satis-
17 fied with this particular aspect; that the judgment as
18 to what is an acceptable level of patient care is within
19 the discretion of the hospitals and there is no inter-
20 ference from the Department of Health in determining
what that standard is?

21 DR. WALLACE: In fact, sir, we would think
22 that the only place that an acceptable level of care,
23 as judged by the medical staff -- it must be left with-
24 in the bounds of the hospital. But we feel that there
25 should be a standards division from some group from the
26 government that would go to the hospital and see whether
27 or not they were in effect providing an acceptable
standard of care.

28 COMMISSIONER FIRESTONE: And you would feel
29 that this is desirable because once the Department of
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3 Health convinces itself that you are providing this
4 standard and acceptable level of medical and hospital
5 care, that this will induce them to say, well, we have
6 to pay these people more money because otherwise it
7 would mean a reduction of the standard?

8 DR. WALLACE: Right, sir, I feel this is the
9 way this could be worked satisfactorily in this province.

10 COMMISSIONER FIRESTONE: Have you approached
11 the provincial government to set up such machinery?

12 DR. WALLACE: Could I ask the Association,
13 as I have not been associated with them too long, whether
14 this approach has been made.

15 MR. ROSS: Not in precisely those terms, no.

16 DR. GOGAN: At the outset of this hospital
17 plan in the Province of Alberta, it was generally ac-
18 cepted that the consulting services which would repre-
19 sent the equipment to a standards division would be pro-
20 vided by the Associated Hospitals of Alberta.

21 This represented a sensible economy by the
22 Province in allowing this consulting service to be
23 developed by the Associated Hospitals, in view of the
24 fact that the hospitals are supported by payments from
25 the hospitals which, of course, eventually become share-
26 able expense, if they are approved, so that the sug-
27 gession that there should be an actual standards division
28 of the department has not been directly, to my knowledge,
29 suggested by the Associated Hospitals.

30 What they have been anxious to do is to
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MR. ROSS: Not in practical terms, no. DR. GOSWAMI: At the onset of this hospital

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What they have been anxious to do is to continue to expand their consulting services in order that a government standards division will be totally



unnecessary in this province.

COMMISSIONER FIRESTONE: Dr. Wallace, I have one last question to direct to you, sir, and that is we have heard from you and your associates and some other groups that there exists a number of deficiencies in the hospital programme as it presently operates, although it has been, generally speaking, a fairly reasonable and successful programme.

Now, since this is a Royal Commission concerned with advising the Federal Government, it would be very helpful to us if you could indicate to us the views of your Association as to whether you feel there should be changes in either Federal legislation or the regulations under that Federal legislation and, if so, what kind of changes in order to deal with the deficiencies which you have outlined exist.

Now, again, this is a condition question. It is one that requires consideration, but if we could have your views it would help us in formulating a recommendation to the Canadian Government. Would it be possible for you to let us have your views on the subject?

DR. WALLACE: Right, sir. We will send them to you.

THE CHAIRMAN: Thank you very much, Judge Buchanan and Dr. Wallace, and those associated with you here this morning.

We have had a full and very down-to-earth discussion of the problems, and the Commission, with the additional information which will be forthcoming, will have profited a great deal from the submission, and at



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the same time I want to thank Mr. Campbell for accepting the invitation which we extended to him to be here this morning.

We will now take a short recess and reconvene.

CHIEF JUDGE BUCHANAN: We would like to express our thanks to you for the privilege of appearing before you. We thank you for your courtesy and consideration.

---A SHORT RECESS

THE CHAIRMAN: The next item. An invitation was extended to the hospitals in Calgary. Dr. Gogan is here to speak to this, and we are grateful to you, Dr. Gogan, for having accepted the invitation to bring forward this information.

DR. GOGAN: Thank you, sir.

THE CHAIRMAN: We have already anticipated in part one of the questions.

DR. GOGAN: That is right, sir.

If I might place on the record I did not have sufficient copies of this article, but I can have them sent to you.

THE CHAIRMAN: If we can have one copy, we will be able to make the others.

---EXHIBIT 137-A: Supplement to the main Submission dated February, 1962.

---EXHIBIT NO. 137-B: An Act to Incorporate the Associated Hospitals of Alberta March, 1948.

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---A SHORT RECESS

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CHIEF JUDGE DUCHANAN: We would like to ex-

We will now take a short recess and

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the invitation which we extended to him to be here this



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---EXHIBIT NO. 137-C: Blue Cross Plan terms & conditions contract.

APPEARANCES:

DR. IRIAL GOGAN

DR. J.C. JOHNSTON

DR. GOGAN: In your letter to Dr. Johnston and myself, sir, we did not understand that you wished us to appear formally as representatives or regional hospital conference and I would like to make it clear that we are appearing as two individuals from the City of Calgary.

THE CHAIRMAN: And with knowledge --

DR. GOGAN: With some knowledge, sir.

THE CHAIRMAN: I will not accept the qualification, Dr. Gogan -- with knowledge of the subjects with respect to which we wrote you.

DR. GOGAN: Thank you, Mr. Chairman.

I will try to be very brief, sir, as I understand the time is rather short.

I would merely point out that we appear to have a severe shortage of beds in the Calgary area, which has led to an occupancy in our adult and children areas of around 95 percent to 100 percent.

Most hospital people think that this level of occupancy is far too high because of the dangers of cross-infection, the difficulty of preparing rooms, etc., for terminal disinfection, and the margin of safety for

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---EXHIBIT NO. 137-C: Bine Cross Plan terms & condition

APPEARANCES:

DR. TRIAL GOGAN

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THE CHAIRMAN: And with knowledge --

DR. GOGAN: With some knowledge, sir.

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have a severe shortage of beds in the Calgary area, which has led to an occupancy in our adult and children areas of around 85 percent to 100 percent.

Most hospital people think that this level

of occupancy is far too high because of the dangers of cross-infection, the difficulty of preparing rooms, etc., for terminal disinfection, and the margin of safety for



contingencies or disaster is extensively slim.

We must also appreciate that this effect of tension on nursing and other staff in the hospital is a factor which has to be considered.

We would like to bring to your attention, Mr. Chairman, some projections of the population situation in Calgary for the year. These estimates are based on a study of Calgary's past and probable population projections. They are made by P.J. Smith of the geography department of the University of Alberta, and they have been modified by P.L. Crisp in a memorandum to the City of Calgary dated December 6th of last year.

I shall abbreviate this, and if you wish the details, I will be glad to give them to you. They do project a population which he reckons for 1961, and we have checked this, and this is reasonably factual, at 276,870 people.

Dr. Wallace, when he was director of the Hospitals Division, estimated that the bed need for a city of Calgary's size and location would be 8 active treatment beds for 1,000 population, which represented an active treatment bed need at the moment of 2,215. He reckoned at 2.5 auxiliary beds from chronic hospitals at 2.5 per thousand, which gave us a minimum bed need of 2,907 combined.

The projection, incidentally, for 1981 on this population study is that Calgary in 1971 will have 432,800 people, and in 1981 will have 670,900 people.

The present bed situation in Calgary is that we estimate that we have available as active beds 747,

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I shall appreciate this, and if you wish the details, I will be glad to give them to you. They do project a population which he reckons for 1981, and we have checked this, and this is reasonably factual, at 376,873 people.

Dr. Wallace, when he was director of the Hospitals Division, estimated that the bed need for a city of Calgary's size and location would be 8 active treatment beds for 1,000 population, which represented an active treatment bed need at the moment of 2,212. He reckoned at 2.5 auxiliary beds from chronic hospitals at 2.5 per thousand, which gave us a minimum bed need

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3 which must now be corrected by the recent addition of
4 200 beds at the Calgary General Hospital. If we add up
5 all the hospitals, the Holy Cross, 342; the Children's
6 Hospital, 128; the Grace Maternity Hospital, 45; and we
7 estimate the active treatment in the Colonel
8 actual bed capacity is over 400, but in terms of length
9 of stay, domiciliary, we count them as 200.

10 When we total these, we find that we have an
11 annual bed deficiency in Calgary of some 1,462 beds.

12 THE CHAIRMAN: Today?

13 DR. GOGAN: Right, now, sir.

14 I am sorry, that should be corrected for the
15 200 recently opened. 1,262.

16 THE CHAIRMAN: What will the Foothills
17 Hospital add to that?

18 DR. GOGAN: 700 beds.

19 THE CHAIRMAN: So that you will be 500 short
20 after that?

21 DR. GOGAN: 500 short, yes, after the con-
22 struction of that. There are other constructions pro-
23 posed. An addition is proposed at Holy Cross, which would
24 add 155 beds.

25 We would feel that there is a need for an
26 immediate start on the planning for another acute general
27 hospital in the City of Calgary. The problem in relation
28 to convalescent and chronic patients in hospital: we have
29 carried out at various times a number of surveys, and
30 the proportion in both hospitals is approximately the
same. Our experience, when we had a priority on ad-
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3 beds is that Holy Cross transferred some 40 patients in
4 Calgary General transferred some 50 patients.

5 We have analyzed our length of stay, because
6 we have noted the impact of hospital insurance programmes
7 on length of stay, and we note that there is an increase
8 of approximately one day on the hospital insurance, since
9 hospital insurance was universally introduced.

10 We feel that this is probably primarily due
11 to the fact that a great number of older people of
12 middle income groups are now able to afford to go to the
13 hospital to have surgery, which previously they could
14 not afford.

15 But, of course, there are other factors, and
16 I would not like to be dogmatic about that. At the
17 present time as far as the patterns of practice in the
18 two hospitals, they are slightly different in that the
19 proportion of surgical admissions to the Holy Cross and
20 surgical procedures is somewhat higher than the Calgary
21 General.

22 There is a difference in the pattern of
23 medical practice there, in that the Holy Cross has got
24 several large groups of doctors who frequent us, whereas
25 Calgary General has only one large group, and has a
26 very large number of independent practitioners.

27 We have not analyzed this down to a point
28 where we could make any practical recommendations in
29 relation to it. It is merely a fact.

30 We have studied waiting periods and we find
that for most elective cases, particularly of a simple
nature, that they wait for as long as from two to eighteen



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3 months. In some cases, such as varicose veins, they
4 have been on our waiting lists in either hospital for as
5 long as eighteen months.

6 Both hospitals recognize as conditions for
7 emergency admission, however, certain factors such as
8 social emergencies, and we give priorities for Workmen's
9 Compensation Board cases, for wage earners, in order to
10 return back to employment.

11 We recognize the problems in connection with
12 housing conditions and family problems, and in the Holy
13 Cross Hospital, particularly, we have a programme of
14 priority or emergency admission for all cases referred
15 from the Provincial Cancer Clinic. The Calgary General,
16 I think, does not work on such a high degree of priority,
17 but it also gives a high degree of urgency, so that
18 their waiting period is reduced.

19 One successful experiment which the Calgary
20 General Hospital has brought into play is the use of what
21 is virtually a day hospital; it has taken a unit of 5
22 two-bed wards and they admit them at seven o'clock in
23 the morning and discharge them that evening. If they
24 find that they can do submucous resections, and other
25 limited procedures. The patients are only discharged
26 in the care of a responsible person. This is an im-
27 portant factor.

28 This, I might add, is an extremely expensive
29 type of programme requiring a high standard of nursing
30 care, a very intensive nursing care, and it is regrettable
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6 sidered this very carefully and analyzed to some extent
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8 course, the Calgary General Hospital does carry the brunt
9 of the load as a city hospital with some 20,000 regis-
10 trations per annum. Holy Cross has 10,000 registrations
per annum, so we carry approximately one-half the load.

11 However, the comments which have been made
12 might suggest that the use of these facilities by physi-
13 cians as an extension of their office is a bad thing.
14 Dr. Johnston and I do not feel this is so. We think
15 that the element of patient care; the availability of
16 properly sterilized matter for suturing, and etc., rather
17 that the emergency department of the hospital, preferably
18 the out-patient, if it existed as such, a preferable
19 place for this type of procedure to the doctor's office
20 in many instances, provided that we recover a sufficient
amount of money to cover our costs, which I believe both
hospitals do.

21 We have felt in Calgary, and have worked
22 closely together in avoiding duplication of services.
23 This could be carried on to a greater extent than it has
24 been, but the Holy Cross Hospital, for instance, has re-
25 sisted inclusion of an artificial kidney in its equip-
26 ment, because we felt that one for the southern Alberta
27 location, the Calgary General Hospital, was enough. For
28 cardiac surgery, it has been carried on at Holy Cross,
29 but it is not being carried on in the Calgary General.
30 There is some duplication on neuro surgery, but the vast



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majority of neuro-surgical procedures is carried on in the Calgary General.

We feel we are aiming gradually to a situation where we will avoid duplication of facilities in the city.

I think, sir, that that covers rather briefly what I had intended to say. Thank you.

THE CHAIRMAN: Dr. Gogan, I observe you are reading from a manuscript or from your notes?

DR. GOGAN: Notes, sir.

THE CHAIRMAN: Are you going to be able to develop those notes into a manuscript form that you could send to us?

DR. GOGAN: Yes, sir, if you find them sufficiently interesting.

THE CHAIRMAN: Not only interesting but I think extremely valuable and your discussion of the co-operation between hospitals whereby one area of treatment is developed in one hospital and one in another is something of extreme interest and may well be both from the standpoint of efficiency and cost. Dr. Johnston, do you wish to add?

DR. JOHNSTON: I do not think so, sir.

THE CHAIRMAN: Well, we are very grateful to you gentlemen for the study you have made and for the information you have given us. We will be extremely grateful to hear from you further.

DR. GOGAN: Thank you very much for your invitation.

THE CHAIRMAN: The next brief is that of



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The submission will be Exhibit 139.

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THE SECRETARY: Exhibit 139A will be Directory
of Community Services for Greater Edmonton.

---EXHIBIT NO. 139-A: Directory of Community Services
for Greater Edmonton.

SUBMISSION OF COUNCIL OF COMMUNITY SERVICES
OF EDMONTON AND DISTRICT

APPEARANCES:

MR. D. HOMERSHAM

MR. D. CRITCHLEY

MRS. C.G. SCAMBLER

MR. HOMERSHAM: Mr. Chairman and honoured
members of the Royal Commission. Mr. Nicholls, Exe-
cutive Director of the Council is unable to be present
this morning. However, may I introduce the members of
the Council who are here: Mrs. C. Scambler is the
director of the Welfare Information Service of the
Council and Mr. David Critchley is the Associate Exe-
cutive Director of the Council. My name is Homersham and
I am President of the Council.

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5743

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5743

represents in the submission of this brief. The Council has some variations in council operations across Canada and the Council of Community Services of Edmonton and District is an elected body and represents a board of some 27 members. The aims and objectives of the council, like most councils, is to contribute to the general well-being of the resident of the community, by planning, developing and instituting in co-operation with the interested individuals, agencies and departments of government.

The second point I would like to mention at this time is that this brief is not an exhaustive study, I suppose it might be called a condensation of information of the material that is available to the council and with which the council is working. I would now like to ask Mr. David Critchley to speak to the brief.

THE CHAIRMAN: Thank you very much.

MR. CRITCHLEY:

OBSERVATIONS ON MEDICAL CARE AND HOSPITAL SERVICES FOR
THE INDIGENT AND MEDICALLY INDIGENT IN THE GREATER
EDMONTON AREA.

1. In preparing this submission it has not been possible to undertake a complete survey of the adequacy of health and welfare services in the Edmonton area. We have, however, information from previous inquiries conducted by the Council of Community Services, and have for the purposes of this submission convened for discussions key persons in the health and welfare fields.

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convened for discussion key persons in the health
and welfare fields.



2. For the purposes of this presentation, we shall refer to the indigent as a person who because of insufficient means receives some form of public assistance. The medically indigent person is able to meet his basic needs for food, clothing and shelter but is unable to meet additional expenditures when a health problem is encountered.
3. It is not the object here to provide an inventory of all health and hospital services available for indigent and medically indigent persons in Edmonton as it is assumed other briefs will describe the scope of existing facilities and services. We will however suggest areas where on a day-to-day basis problems in receiving needed services are seen to be encountered.
4. As a central social welfare planning body serving Edmonton and District the Council of Community Services is well aware of close relationships between health and welfare problems and services. It has been established that low income and increased incidence of illness or disease are frequently related. As a result ill health is a major factor in welfare need. Some indication of this fact is contained in reports of the Edmonton City Welfare Department. In the past three years the proportion of cases in which ill health was the major factor leading to indigency has varied between 19 per cent and 35 per cent of the total caseload.
5. It is our impression that in the main medical and hospitalization provisions for indigent persons are



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It is our impression that in the main medical and hospitalization provisions for indigent persons are



reasonably comprehensive. Families where the breadwinner is missing receive greatest help. However, families on marginal income face real problems in maintaining economic independence when faced with a major health problem.

6. It is the opinion of senior health and welfare leaders that there is insufficient knowledge of the existence of many health and welfare services. As a result many people requiring help are unaware of resources presently available to them.

7. Gaps and inadequacies in health services and facilities do exist and we would like to make reference to those with which we are familiar:

a) Many individuals and families are not able to pay for drugs, special diets or appliances which are considered essential for treatment and they are, therefore, obtaining inadequate health care, and are not able to benefit from the treatment they already have had. On an individual basis attempts are made to secure help from voluntary service groups in the community. While response has often been sympathetic, we believe this is essentially a hit or miss way of meeting the problem and tends further to contribute to and increase the individual's dependency.

b) Emergency homemaker services and home care programs are in exceedingly limited supply. Systematic development of these services would provide for more economic use of acute and convalescent hospital facilities. We believe the

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4 voluntary service community has well demonstrated
5 the value of these services and they now should
6 be extended under governmental auspices or given
7 adequate financial support through governmental
8 sources.

9 We have not elaborated on this subject but would
10 draw your attention to the material submitted to
11 the Commission by the Edmonton Family Service
12 Bureau yesterday.

13 c) The Council of Community Services supports having
14 medical social service departments available in
15 all general hospitals. It has been established
16 that many patients upon discharge from hospital
17 return to home and community conditions that have
18 been directly or indirectly responsible for their
19 hospitalization in the first place. A social
20 service department has as one of its primary
21 responsibilities the successful rehabilitation
22 of the patient to his home and community. Where
23 such departments do not exist it is evident that
24 hospital personnel, if for no other reason than the
25 demands of their heavy schedules, cannot under-
26 take this post-hospital rehabilitation responsi-
27 bility. In Edmonton, only one of the four general
28 hospitals has an operating social service
29 department.

30 d) Edmonton is a medical and hospital center for the
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d) Edmonton is a medical and hospital center for the northern part of Alberta. It is our observation that detection and diagnostic facilities in outlying areas are comparatively inadequate.



As a result many individual health problems treated in Edmonton, arise from inadequate preventive, detection and diagnostic services in outlying areas. In particular, we would point to recent studies which indicate a significantly higher incidence of health and welfare problems of Indian and Metis people resident in Alberta. In our opinion this situation indicates the need for auxiliary health services for Alberta residents living in areas removed from main medical and hospital centers.

e) The need for further development of adequate services and a sufficient number of qualified personnel for rehabilitation services for the physically handicapped has been recognized for a number of years by this Council.

We would draw attention to the attached statement on a central registry for the handicapped. In addition we support measures to establish central assessment for the physically handicapped, particularly for those individuals whose disabilities fall outside the scope of the Workmen's Compensation Clinic and veterans' services.

We believe, in terms of personal fulfillment, as well as ultimate savings to the general public, that rehabilitation services should be increased to include all of the skilled personnel and services needed to assist a person to recover from illness or disability in order that he can use his capacities to the fullest extent possible



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Critchley

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(medical social psychological, physio-
vocational counselling, special employment
counselling and placement).

If I may comment for one minute. Our Council
last spring conducted a one day problem census of com-
munity service workers and volunteers in the community
and it was quite interesting that well over 50 percent
of the problems related to rehabilitation. This, from
a research point of view, is not significant but it is
significant that they consider this to be such a major
problem.

8. Dental Care for Families of Marginal Income: In
recent months it has been drawn to the attention of
the Council of Community Services that there are
serious lacks in the provision of dental care for
families of marginal income in the Edmonton District.
This has been borne out from the experience of the
Welfare Information Service of the Council as a
significant number of individual requests have been
made for dental service for which there have been
no available resources for referral.

We are currently studying this matter as serious
gaps in dental services are bound to affect adverse-
ly the general health of the residents of the greater
Edmonton district. Following is a brief review of
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3 a) School of Dentistry, University of Alberta -

4 The school is primarily a teaching clinic. Appoint-
5 ments are made in August for the ensuing year and
6 some families with marginal income are able to bene-
7 fit from clinical services. There is no dental ser-
8 vice in the Out-patients Department of the University
9 Hospital. Our observations would lead us to see a
10 need for emergency treatment.

11 b) School Dental Program - Aside from the pre-

12 ventive work done through the school dental service
13 of the City Public Health Department, a school age
14 child may be given dental treatment if requested by
15 the parent. While a certain amount of work can be
16 done on this basis it is not a primary function of
17 the Public Health Department to provide this service
18 as its main objectives must be to concentrate on
19 primary prevention and secondary prevention (referral
20 for treatment). There is no program available for
21 the pre-school child nor for the child who has left
22 school and is in the 15 to 17 year-old age group.
23 In the area of orthodontist services, it has been
24 suggested only 1/8 of 1% can afford a long term
25 dental program of this nature and the only referrals
26 to our knowledge which can be made for this type of
27 service are for hospitalized cases.

28 c) Provision for those on Public Assistance - It

29 is reasonable to assume that dental care is available
30 for families in receipt of social assistance or
public assistance. Some of this work is done through
the Public Health Department and some referred to



a) School of Dentistry, University of Alberta -

The school is primarily a teaching clinic. Appointments are made in August for the ensuing year and some families with marginal income are able to benefit from clinical services. There is no dental service in the Out-patients Department of the University Hospital. Our observations would lead us to see a need for emergency treatment.

b) School Dental Program - Aside from the preventive work done through the school dental service of the City Public Health Department, a school child may be given dental treatment if requested by the parent. While a certain amount of work can be done on this basis it is not a primary function of the Public Health Department to provide this service as its main objectives must be to concentrate on primary prevention and secondary prevention (retention for treatment). There is no program available for the pre-school child nor for the child who has left school and is in the 15 to 17 year-old age group. In the area of orthodontist services, it has been suggested only 1/3 of 1% can afford a long term dental program of this nature and the only referrals to our knowledge which can be made for this type of service are for hospitalized cases.

c) Provision for those on Public Assistance - It is reasonable to assume that dental care is available for families in receipt of social assistance or public assistance. Some of this work is done through the Public Health Department and some referred to



dentists in private practice. Financial responsibility has been assumed by the government in these cases. We are not in a position to evaluate the type of care given, i.e., whether it is simply emergency or whether more extensive dental programs may be made available. However, it has been noted that there is no service in the area of dental care which corresponds to the services of the out-patients department of the University Hospital. It is therefore frequently necessary to 'shop' for needed dental care.

d) Private Arrangements - There is indication that some dentists will give free or reduced rate dental work to families where it is known that income is insufficient. We also know that many families do not wish to seek this type of assistance because they know that they cannot meet an obligation. The problem is particularly acute in families where there is a large number of children and too small an income to obtain needed dental care.

9. Attached to and as part of this submission is a statement on health of older citizens. This material has been derived from a survey conducted by the Council of Community Services and was prepared by Dr. R.L. James, Department of Sociology, University of Alberta.
10. On the basis of a meeting called by the Council in January to discuss problems that indigent and medically indigent persons meet in obtaining health and hospital services the following questions and problems were raised. We believe they merit further examination:

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8 ficiently broad in scope to assure needs will
9 be met on a priority basis.

10 I might mention the comprehensive plan
11 should be denuded of its emotional charge; we mean a
12 comprehensive plan but not any comprehensive plan.

13 b) There is awareness of individual cases where
14 families spend their entire savings and go into
15 debt rather than accept 'charity'. Should we
16 not be systematically reviewing the circum-
17 stances of the non-indigent family. Such at-
18 titudes on the part of those who do not want to
19 depend on outside help may well have seriously
20 damaging effects on family and individual in-
21 tegrity, the extent of which to our knowledge
22 has not been subject to analysis.

23 c) Few families can afford loss of income due to
24 illness for a long period of time, whether
25 insured or not. Provision for sickness pay
26 benefits vary greatly and it would appear many
27 Canadians are not covered by such benefits. It
28 should be noted Unemployment Insurance does not
29 cover a person who becomes ill on the job. It
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Critchley

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11. The Council of Community Services wishes to draw special attention of the Royal Commission on Health Services to the brief to be submitted by the Canadian Welfare Council with which this Council is affiliated.

In conclusion, may we say we strongly endorse the investigation being conducted by the Royal Commission. We believe it to be most important, however, that all concerned not lose sight of the fundamental challenge: to eliminate ill health and the inability to withstand its economic demands from its present position of being among the major contributing factors to personal and family disorganization, disintegration, and dependency.

THE CHAIRMAN: Thank you, Mr. Critchley.

COMMISSIONER BALTZAN: I have one question. I appreciate everything you said but I do not know whether I heard you right; did you say in Edmonton one hospital in four has a social service department? Did I hear you right?

MR. CRITCHLEY: Yes sir, that is right.

COMMISSIONER BALTZAN: Could you possibly tell me what prevents the other hospitals from establishing social service departments? What is in the way? You advocate it and it is saving, it is useful for this position of patients in shortening hospital stay so what prevents the other hospitals? Do they believe in the philosophy?

MR. CRITCHLEY: If I may be permitted a comment that is only a personal observation. I think we have done no more than recommend that such departments



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Critchley

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be established. I think that it would be largely a question of the need to accept the need for such a department, a question of philosophy, and, I suppose, the other factor of money. We are in no position to provide any specific information.

THE CHAIRMAN: What about personnel, Mr. Critchley, availability of personnel?

MR. CRITCHLEY: Well, it is certainly a major problem. I think others would be in a better position to suggest whether it is actually the problem that is preventing the establishment of such departments.

COMMISSIONER STRACHAN: It is stated there is no dental service in the out-patient department at the University Hospital, are there such services at any of the other large hospitals?

MR. CRITCHLEY: I wonder if Mrs. Scambler could speak as to that.

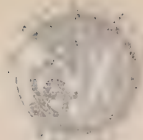
MRS. SCAMBLER: Only if a person appears with a major, could I say quite quickly, a swollen face and the tooth is extracted in the emergency. They are no established dental services as part of the emergency service of any of the other hospitals.

COMMISSIONER STRACHAN: Who renders that service?

MRS. SCAMBLER: Who renders the service in the hospital? I am sorry, Dr. Strachan, I couldn't tell you that. I don't know whether it is the physician in charge or a dentist that will be called in.

COMMISSIONER STRACHAN: Are they on call?

MRS. SCAMBLER: I can't tell you that, I



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Critchley

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COMMISSIONER STRACHAN: Has any attempt been made to establish dental service in the out-patient department?

MRS. SCAMBLER: This current study referred to here, in which you see some reference made, is presently discussing this particular matter in conjunction with the Dental Association of Alberta.

COMMISSIONER STRACHAN: Thank you. This study or inquiry was started about July. It picked up momentum in September or November, and the final draft is in the hands of the Dental Association now.

THE CHAIRMAN: Mr. Critchley or Mr. Homersham, it has been suggested at various times that the lack of social workers at certain institutes and at certain levels is due to lack of personnel, of trained social workers. I understand there is no school for the training of social workers in Alberta. Would your organization or group have any views to offer on the advisability of having a school of social workers established on the campus of the University of Alberta?

MR. CRITCHLEY: As a Council we haven't detailed this subject, we haven't isolated it for specific consideration. To my knowledge the major work on this question was done by the Local Association of the Canadian Association of Social Workers. As a Council we really are not in a position to comment. We are well aware of the tremendous demands for social workers and also the difficulty in obtaining them. Part of what I think, is the difficulty in bringing them from the



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THE CHAIRMAN: Do you think that the opportunity might arise whereby you might be able to give consideration to this question because of the fact that you have such a broad coverage?

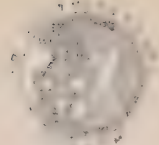
MR. CRITCHLEY: It is widespread community discussion at the present time.

THE CHAIRMAN: If, within the reasonable future, some opinion was arrived at would you be able to send it forward to us? It would be something we would like to have.

MR. HOMERSHAM: I would like to assure you if the Council is asked to endorse such a movement we would be only too happy to come forward with the material on this for you.

THE CHAIRMAN: Thank you very much, Mr. Homersham. Like a number of others your Association is here today at the invitation of the Commission because we were most anxious to have the facts and views and information from organizations and groups such as yours. We are very grateful to you for responding to our invitation. We appreciate the time and consideration that went into the preparation of your brief, of your submission, and into the preparation of the supporting documents attached which contain the information that we want for our research people. We are grateful to you and extend the thanks of the Commission to you for accepting our invitation and for being so helpful.

MR. HOMERSHAM: Thank you very much, Mr. Chairman. May I extend on behalf of the Council our



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4 THE CHAIRMAN: Then Dr. Higgins has in-
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6 Higgins.

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9 SUBMISSION OF DR. G.K. HIGGINS, MD.

10 APPEARANCES:

11 DR. G.K. HIGGINS
12
13 ---

14 THE CHAIRMAN: Your submission, Dr. Higgins,
15 will be no. 140.

16 ---EXHIBIT NO. 140: Submission of Dr. G.K. Higgins.

17 DR. HIGGINS: Mr. Chairman, Members of the
18 Commission: I welcome this opportunity to present a
19 personal brief to the Royal Commission. The observations
20 that I have to make are entirely my own. Nobody else is
21 responsible in any way. I would like to say that some
22 of the things that I have to say I feel very strongly
23 about. I would also like to say I am not an angry young
24 man. I am very proud of the position that the doctors
25 of Alberta have taken, are taking. I am very proud of
26 the vrief they submitted in a constructive sense and
27 concur entirely with that submission. I would also like
28 to say I am indeed grateful for the efforts the Govern-
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What I have attempted to do is to study the experience of the past and try and project it into the future so that we may all profit from the lessons and mistakes of history. In this presentation I would like to read the first few pages until I come to the recommendations and then I would like to just state a paragraph or two from each section, if I may be permitted to, and then finally come back to the recommendations.

PURPOSE OF THE BRIEF

1. A personal opinion will be expressed in an attempt to explain the objections of the great majority of the medical profession to a compulsory universal form of health insurance controlled and operated by the state which will be referred to as Socialized Medicine.

It is hoped that by making these reasons known to the Government of Canada through this Royal Commission on Health Services, principles may be established which will aid all concerned in the achievement of the best possible medical care for the people of Canada.

SUMMARY OF THE FIVE SECTIONS OF THE BRIEF

2. SUMMARY OF PART I: (which is entirely excerpts from "On Liberty" J.S. Mills.) In these excerpts the following is shown:

The relationship of the individual and the state



2757

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3 is studied, more particularly the individual in a
4 democratic state.

5 The tendency of the state to assume ever in-
6 creasing authority over the individual and the danger
7 inherent to individual freedom and liberty and
8 eventually to the state itself are studied. The
9 right of the individual to think and act for himself
10 is reviewed.

11 A protest is made against the increasing ten-
12 dency of governments to direct and control individual
thought and action.

13 The need for great moral strength and conviction
14 on the part of the individual to resist intrusions
15 by the state in areas of personal concern is stressed.

16 Now, my own again.

17 A great public debate is being undertaken and a
18 scholarly study is now in progress concerning the
19 proper action of government in the area of human
20 affairs involving personal health. It is suggested
21 that it is appropriate to review Mill's "Essay on
22 Liberty" for a proper understanding of that essay
23 is now most timely and due regard should be given to
24 the consequences of State interference with the
personal liberty of the citizen.

25 SUMMARY OF PART II

- 26 3. The evolution of the National Health Service in
27 Great Britain is described. The description shows
28 how the State has created a monopoly for medical
29 services, how a master-servant relationship has been
30 created between the State and the hospital doctors.



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The Hippocratic principle, a principle older than Christianity which has survived all manner of assault, and a principle setting forth the overriding duty of a doctor to his patient, is shown by the review of the National Health Service to have been cast aside. The patient is now merely an article of commerce in a contract between the State and the Hospital Doctor.

An ancient proud and noble profession has been reduced to servitude.

SUMMARY OF PART III.

4. The general relationship between demand for medical services and the supply of medical services is shown.

Socialized medicine does not increase the total medical care available.

Total medical care available can be expressed in the following manner:

$$\text{TOTAL MEDICAL CARE AVAILABLE} = E \left[\begin{array}{c} \text{Number} \\ \text{of} \\ \text{Doctors} \end{array} \times \begin{array}{c} \text{Hours} \\ \text{of} \\ \text{Work} \end{array} \right] + K_1$$

$$\left[\begin{array}{c} \text{Ancilliary} \\ \text{Personnel} \end{array} \right] \times \left[\begin{array}{c} \text{Hours} \\ \text{of} \\ \text{Work} \end{array} \right] + K_2 \left[\begin{array}{c} \text{Other} \\ \text{Ancilliary} \\ \text{Services} \end{array} \right]$$

Both the ancilliary personnel and the hours of work and the other ancilliary services, of course, modified by the factor of efficiency.

I have defined E as a complex factor that correlates and expresses Doctor skill, availability, zest and zeal, help from ancilliary services and time lost in dealing with petty complaints, numerous



Christianity which has survived all manner of assault, and a principle setting forth the overriding duty of a doctor to his patient, is shown by the review of the National Health Service to have been cast aside. The patient is now merely an article of commerce in a contract between the State and the Hospital Doctor. An ancient proud and noble profession has been reduced to servitude.

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Both the ancillary personnel and the hours of work and the other ancillary services, of course, modified by the factor of efficiency. I have defined E as a complex factor that correlates and expresses Doctor skill, availability, zeal and zeal, help from ancillary services and time lost in dealing with petty complaints, numerous



and unnecessary house calls, unreasonable demands, the filling out of numerous forms; arguing with officials, fatigue from too long hours, attempting to see too many people in too little time (too much dead spare work, too little vital work) etc. and can be thought of as Efficiency. Where K_1 and K_2 are similar complex factors that express the efficiency of the ancilliary personnel and other ancilliary services.

Socialized medicine would increase the demand on an already inadequate supply of doctor services. Such an increased demand would lead to a loss of efficiency resulting in an absolute decrease in total doctor care available. There would be too little time for too many patients.

The demand for and supply of doctor care may be expressed in the following manner:

Demand for Doctor Care, Total Doctor Care Available

Number of people with complaints \times Doctor care available per complaint =

Number of Doctors \times Hours at Work

The total number of doctors times the doctor hours of work modified by the efficiency factor. Certain questions are asked on the basis of these concepts.



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SUMMARY OF PART IV

5761

SECTION A

5. The conditions that actually did evolve under the National Health Service is recorded. The practical limitation of the amount of money the state can spend for medical services is shown.

If I may digress, it was shown here this morning to some extent.

The state instead of the individual decides how much is spent for medical services. A form of rationing by queuing results. The absolute decrease in the number of medical students is shown.

The failure of the Doctor/Population ratio to show increased improvement is pointed out. The inability of Hospitals to fill their junior posts except from overseas is shown. The lack of hospital construction is noted.

SECTION B -- Forecast of the Effect of Socialized
Medicine in Canada

SUMMARY OF PART V.

6. Socialized medicine has created a discontented profession in Britain where successive Ministers of Health have used this extraordinary power to exploit doctors in the interests of financial stability. Political decisions replace personal choice. Individuals and not the state should decide on the amount to be paid for medical services. Socialized medicine does not increase the amount of medical care available. This series of events must not happen in Canada.

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2771

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3 The doctor must never be in contract with or under
4 the direction of the Government with the patient as the
5 subject matter of the contract.

6 The HIPPOCRATIC principles, that the doctor's over-
7 riding duty and obligation is to his patients must
8 never be over ruled. The patient must possess the
9 right of free choice of doctor.

10 Both patient and physician must have the right to
11 terminate the relationship at will.

12 I will turn to no. 31 on page 17. This is
13 the concluding part of part 1 and it is from Dr. Mills.

14 A government cannot have too much of the kind of
15 activity which does not impede, but aids and stimu-
16 lates, individual exertion and development. The mis-
17 chief begins when, instead of calling forth the
18 activity and powers of individuals and bodies, it
19 substitutes its own activities for theirs; when, in-
20 stead of informing, advising and, upon occasion,
21 denouncing, it makes them work in fetters or bids
22 them stand aside and does their work instead of them.
23 The worth of a State, in the long run, is the worth
24 of the individuals composing it; and a State which
25 postpones the interests of their mental expansion and
26 elevation to a little more of administrative skill,
27 or of that semblance of it which practice gives, in
28 the details of business: a State which dwarfs its
29 men, in order that they may be more docile instruments
30 in its hands even for beneficial purposes -- will find
that with small men no great thing can really be
accomplished; and that the perfection of machinery to



The doctor must never be in contract with or under the direction of the Government with the patient as the subject matter of the contract.

The HIPPOCRATIC principles, that the doctor's overriding duty and obligation is to his patients must never be overruled. The patient must possess the right of free choice of doctor.

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3 which it has sacrificed everything will in the end
4 avail it nothing, for want of the vital power which,
5 in order that the machine might work more smoothly, it
6 has preferred to banish.

7 I now go to no. 35 on page 20.

8 A Further Digression -- HEALTH CARE A RIGHT?

9 It must be realized there can be no right without
10 a corresponding duty. If one states that there is a
11 right of every Canadian to medical care, on whom does
12 the duty lie to provide such care? At present it is
13 a duty discharged by the medical profession, ancil-
14 liary services, governments, and the individual need-
15 ing the care. If it is considered that the duty must
16 rest primarily on the State, the State can only dis-
17 charge the duty by civil conscription of the medical
18 profession, and the ancilliary services, and by
19 regulating the individual needing the care. While
20 such a method of discharging the duty may for a time
21 enable the state to discharge its duty by enforcing
22 upon certain persons a duty to make medicine their
23 career. An exercise of legislative power to force
24 certain individuals to enter a particular profession
25 can scarcely be contemplated in this country or be
26 compatible with democratic principles. All can agree
27 however that the State, the profession and the people
28 (whose common good is forever bound together) have a
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30 The area of difference is how this can best be
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3 In other words if nobody studies medicine
4 or if they emigrate to another country who is going to
5 provide that right?

6 A Further Digression -- THE ESSENTIAL QUESTION

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8 The essential question and difference is as to what
9 method of payment will most nearly achieve the common
10 goal: The best possible medical care for all.

11 Now we come to 63, page 41. In part 3,
12 certain facts were put, certain questions are now asked.

13 Certain questions are now appropriately asked re-
14 garding the supply of medical care.

15 (1) Will State Medicine increase or improve the
16 total available supply of professional
17 medical care? If so, how?

18 (2) Will the number of medical doctors increase
19 under a State service? If so, why?

20 (3) Will the quality of medical doctors improve
21 under a State Service? If so, how?

22 (4) Will the medical doctor work longer or
23 shorter hours, then he now does, under a
24 State service? If so, why?

25 (5) It is recognized that medical efficiency
26 parallels the availability of good ancilliary
27 services such as hospitals, nurses, labora-
28 tory services, rehabilitation facilities, etc.

29 Since the advent of Federal Provincial
30 Hospital Plans, the demand for these services
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(1) Will socialized medicine insure equality of
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prompt and efficient service?

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I now go over to Paragraph 82, page 53, part
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Leading up to this, I make the point, dig-
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Now, paragraph 89, page 56, the conclusion:

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CONCLUSION

1. Canadians are embarking on a great national debate
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2. There are two opposing view points.
3. Politicians and Political Parties are promising
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fulfilled unless "the right of the citizen to owe his existence and continuance in society not to the arbitrary will of another, but to his own rights and powers as a member of the Commonwealth" (Kant) is abrogated.

5. If the state assumes responsibility for medical care, it would be impossible to combine that responsibility with any lack of ultimate jurisdiction -- This can lead only to a master-servant relationship -- This can lead only to the state of affairs described above -- To this the profession will not consent -- It can hardly be expected to preside over its own debasement and entry into servitude, to honour the promises and aid the political expediency of a philosophy totally contrary to the ancient tenets of medical ethics.

6. Evil days will come if promises are made that cannot be fulfilled. There is danger the people will not understand the thwarting of their democratically expressed will, nor realize its achievement could infringe upon the rights and liberties of others. There is danger the people will not understand the reasons for the medical profession's opposition to Socialized Medicine.

7. A famous quotation may help in appreciating the philosophy of the Profession; the obvious overstatement will be understood -- Abbott of Arbroath re: Edward I and the enforced union of Great Britain "so long as there remains a hundred of us alive we will never consent to subject ourselves to the



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dominion of the English, for it is not glory, it is not riches, neither is it honour, but it is liberty alone that we fight and contend for which no honest man will lose but with his life."

8. And for those promising social change based on the services and known opposition of others: Burkes' statement, "If I cannot reform with justice, I will not reform at all", is suggested.

All of which is respectfully submitted.

And now to my recommendations, page 4, no. 7.

RECOMMENDATIONS

7. 1. It is recommended that the Parliament of Canada restrict its legislative power by an addition to the Bill of Rights to the effect that legislative power shall not be so exercised as to authorize any form of civil conscription. A precedent exists in the constitution of the Commonwealth of Australia.
8. 2. In the light of the susceptibility of democracy to the mischief of demagogues, and recognizing as Hobbes says of popular assemblies "that they are as subject to evil counsel, and to be seduced by orators, as a monarch by flatterers" and realizing that, as a result, democracy tends to degenerate into government by the most popular orator, it is felt that the medical profession, short of civil conscription, should not and would not enter into a plan of medical care under which the authority for care of personal health rests with the state, and it is recommended



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that the sound and proper basis of such a position by the medical profession be made abundantly clear.

All of which is respectfully submitted, sir.

THE CHAIRMAN: Thank you very much, Dr. Higgins.

It is very obvious that your submission is the result of a great deal of thought, preparation, and serious consideration and study on your part. I do not know whether any members of the Commission have any questions to put to you. You will appreciate that your submission differs in essence from some of the others. I mean, not in its -- not merely because it poses views not put forward by others, but it is a philosophical discussion, and as you say "The great debate is off.", and whether anything would be gained by questioning, which would be merely a today facet of that great debate, whether it would add anything to what you have said, I do not know.

COMMISSIONER BALTZAN: I have no questions, sir, only to state to you, Dr. Higgins, this is a profound essay and gives food for much thought.

THE CHAIRMAN: The Commission is grateful to you, Dr. Higgins, for this work. It is necessarily provocative, in a sense, but it is from works of a provocative nature that much good can come. It is work of this kind which will, when we study it, require us to have in mind the principles and views that you have put forward and your submission becomes part of the record and will have our consideration in the final analysis.

DR. HIGGINS: Thank you, sir, and gentlemen



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THE CHAIRMAN: We will now recess until
two o'clock, when we will proceed with the submission
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---RECESS:



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--- On resuming at 2.00 o'clock

THE CHAIRMAN: The first brief this afternoon is that of the Edmonton Chamber of Commerce.

THE SECRETARY: That will be exhibit 141.

SUBMISSION

of the

EDMONTON CHAMBER OF COMMERCE

APPEARANCES:

D. F. MARLETT

G. L. ROPER

DR. A. H. MACLENNAN

MR. ROPER: You have our brief and I would assume you would want me to read the recommendations or part of it.

THE CHAIRMAN: Yes, if you will.

MR. ROPER: I might say that this brief comes from the Edmonton Chamber of Commerce representing eighteen hundred members representing a cross-section of business and professional men in the Edmonton district, including agriculture.

RECOMMENDATIONS

The Edmonton Chamber of Commerce recommends:

1. That the provision of medical care be based on the principle of private competitive enterprise.

On resuming at 2.00 o'clock

THE CHAIRMAN: The first brief this afternoon is that of the Edmonton Chamber of Commerce. THE SECRETARY: That will be Exhibit

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APPENDICES:

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cross-section of business and professional men in the

Edmonton district, including agriculture.

CONCLUSIONS

The Edmonton Chamber of Commerce recommends

that the provision of medical care be based on the

principles of private competitive enterprise.



2. That the expansion of Voluntary Prepaid Medical Services Insurance coverage should be encouraged. This insurance can best be provided on a competitive basis by various types of insurance carriers.
3. That Medical Care be made available to those uninsurable for reasons of chronic illness or of inadequate income. Government financial participation in the provision of this care should be based on careful screening processes at the local level. The responsibility of payment of medical services must rest primarily on the individual.
4. That Federal and Provincial Health authorities have due regard to the implications of the ever increasing demands for Welfare Benefits. There is a serious danger that any major increase in welfare expenditures, which imply increased tax burdens, would retard rather than advance business expansion and job opportunity.

THE CHAIRMAN: Thank you very much.

COMMISSIONER FIRESTONE: Mr. Roper, you speak in paragraph 2 of your recommendations, you say:

"This insurance can best be provided on a competitive basis by various types of insurance carriers."

When you speak of competitive basis, you mean competitive in price and coverage?

MR. ROPER: Yes, sir.

COMMISSIONER FIRESTONE: You realize that some commercial contracts may provide lower priced policies than perhaps M.S.I. but, of course, coverage



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MR. ROBERT: Yes, sir.

25 that some commercial contracts may provide lower priced
 26 policies than perhaps N.S.I. but, of course, coverage



1 may not be expensive, so when you speak of competition
2 you mean price and coverage?

3 MR. ROPER: Yes, sir.

4 COMMISSIONER FIRESTONE: In paragraph
5 3 of your recommendations you recommend:

6 "That Medical care be made available
7 to those uninsurable for reasons of chronic
8 illness or of inadequate income."

9 DR. MACLENNAN: Well, it has been
10 suggested as one possible means of implementing this
11 would be when a man deserves or is eligible for unemploy-
12 ment insurance that his allowance can be -- if he is
13 insured under some scheme previously that his allowance
14 can be increased to the amount required to carry his
15 medical insurance while he is unemployed.

16 COMMISSIONER FIRESTONE: Would your
17 Chamber of Commerce recommend such an arrangement?

18 MR. ROPER: That would have to be con-
19 sidered by a council of the Chamber of Commerce.

20 COMMISSIONER FIRESTONE: By the Council
21 of the Edmonton Chamber of Commerce?

22 MR. ROPER: Yes.

23 COMMISSIONER FIRESTONE: Has the
24 Council given any thought of how the recommendations which
25 you have made in this report could be implemented? These
26 are laudable objectives but as a Royal Commission we
27 are not just interested in general statements but also
28 in finding out how these recommendations can be
29 implemented. Have you given any thought as to how some
30 of these can be implemented?



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1 MR. ROPER: No, we have not. Our brief
2 is basically a statement of policy from the Chamber of
3 Commerce.

4 COMMISSIONER FIRESTONE: In other words,
5 you feel you would rather deal with the broad principles
6 rather than make any concrete recommendations as to how
7 these principles can be put into practice?

8 MR. ROPER: That is right.

9 COMMISSIONER FIRESTONE: Perhaps my
10 subsequent questions will be confined to those principles.
11 Now, you say in the same paragraph:

12 "Government financial participation in
13 in the provision of this care should be based
14 on careful screening processes at the local
15 level."

16 What is meant by "careful screening
17 processes at the local level"?

18 MR. ROPER: Well, that is some type of
19 a means test, I imagine, that would carefully screen this
20 sort of thing so that the costs would not get out of line
21 in such an operation.

22 COMMISSIONER FIRESTONE: Well, do you
23 have in mind in this paragraph 3 that people who cannot
24 afford to pay for this medical care service should have
25 it paid by the state?

26 MR. ROPER: That is a good question and
27 I am not sure I can answer that. In paragraph 2 I think
28 that question is probably answered in the original
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30 "The Chamber believes that in a free



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7 ... services."

8 COMMISSIONER FIRESTONE: If I under-
9 stand this paragraph correctly, and please correct me if
10 I my understanding is not quite correct, would you
11 visualize as you call it the government or the state to
12 pay for medical care service for those who cannot afford
13 to pay for this service themselves?

14 MR. ROPER: That is right.

15 COMMISSIONER FIRESTONE: When you speak
16 of the government or the state do you have in mind the
17 municipal government, the federal government or the
18 provincial government; what do you mean by government?

19 MR. ROPER: I do not know whether I
20 can answer that question. I think it is a combined
21 effort, if I were speaking personally.

22 COMMISSIONER FIRESTONE: I take it when
23 you speak of government you have in mind the provincial
24 government together with local authorities which form
25 part of the regional government and if this field cannot
26 carry the whole burden it would be helped by the federal
27 government to take part, is that your view?

28 MR. ROPER: Yes.

29 COMMISSIONER FIRESTONE: Now, if the
30 federal government were to make a contribution to the



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federal government were to make a contribution to the



1 medical care plan for the province of Alberta to take
2 care of the needs of those who cannot pay for the plan
3 themselves, the federal government might then find it
4 necessary to raise taxes to pay for its share of such
5 a plan. Now, if this were the case, would the Edmonton
6 Chamber of Commerce support increases in taxes to pay
7 for such extended service?

8 MR. ROPER: This is another question
9 that I could not answer without Chamber of Commerce
10 Council permission. The executive council would have to
11 meet and pass on such a thing. This today is being done,
12 I believe, and I would imagine that the Chamber of
13 Commerce would be behind such a movement if it meant
14 increased taxes to pay for the needy if they were sure
15 it was for the needy and properly administered.

16 COMMISSIONER FIRESTONE: That is a
17 straight forward answer and I am obliged to you. Thank
18 you very much.

19 COMMISSION BALTZAN: In paragraph 4 in
20 your reference to major increase in welfare expenditures,
21 can it be said that increase is actually a reflection
22 of the Canadian economy? In other words, when the
23 Canadian economy is good then the requirement for social
24 welfare is reduced?

25 MR. ROPER: I am not so sure it is
26 reduced in direct proportion. The Canadian economy has
27 been good over the last number of years but expenditures
28 for welfare have also gone up.

29 COMMISSIONER BALTZAN: What are the
30 underlying conditions in your estimation?



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COMMISSIONER BARTMAN: This is a
strategic forward answer and I am obliged to you. Thank
you.

COMMISSIONER BARTMAN: In paragraph 4 in
your reference to health increase in welfare expenditures,
can it be said that increase is actually a reflection
of the Canadian economy? In other words, when the
Canadian economy is good then the requirement for social
welfare is reduced?

MR. ROYER: I am not so sure it is
reduced in direct proportion. The Canadian economy has
been good over the last number of years but expenditures
for welfare have also gone up.

COMMISSIONER BARTMAN: What are the



1 MR. ROPER: Well, maybe it is something
2 that if I were to speak personally, and anything I say
3 other than what is in the brief must, of course, be
4 personal, the very principle in the brief I think that
5 we state here is to keep a curb that these expenditures
6 do not increase in proportion to anything whether the
7 economy is good or not.

8 COMMISSIONER BALTZAN: Keep a curb on
9 this rather than extending the activities, tend towards
10 greater employment, better wages, more for the people
11 to take home, etcetera?

12 MR. ROPER: I do not know whether I
13 quite understand what you are getting at here. I do not
14 think the Chamber of Commerce is opposed to social
15 welfare as such when needed.

16 COMMISSIONER BALTZAN: I did not imply
17 that at all. I am just looking for a reason. I have
18 the impression and want to be corrected if I am wrong,
19 that when things are at a top level in the way of
20 employment and earnings there would not be that much
21 demand for so much assistance. That is the way I put
22 the question and I have that impression. Am I wrong?

23 MR. ROPER: That may be correct, it
24 would seem that the better things and the more job
25 opportunities there are and the more stable the economy
26 is there would be less need for social welfare. However,
27 it seems no matter how good the economy is there is a
28 good section of the people in the country that need this
29 help and the Chamber of Commerce, of course, is not
30 against this, that is for sure.



MR. ROBERT: Well, maybe it is something

that if I were to speak personally, and anything I say
other than what is in the brief must, of course, be
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COMMISSIONER PATRICK: Keep a curb on

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greater employment, better wages, more for the people
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it seems no matter how good the economy is there is a
good section of the people in the country that need this
help and the Chamber of Commerce, of course, is not
against this, that is for sure.



1 COMMISSIONER BALTZAN: That is not
2 denied in the question nor in your answer. It does
3 seem to connect one with the other, more earnings, more
4 opportunity of increased activity in the business life
5 and there is less demand.

6 MR. ROPER: I think that is right.

7 COMMISSIONER BALTZAN: I have made my
8 point, thank you.

9 THE CHAIRMAN: Thank you, Mr. Roper.
10 Your brief is clear, you state your position clearly and
11 frankly, and it will have our consideration.

12
13 SUBMISSION

14 of the

15 CHARTERED PHYSIOTHERAPISTS OF ALBERTA

16
17 APPEARANCES:

18 MR. W. L. JARMAN

19 MISS NANCY RANDALL

20
21 THE SECRETARY: This will be exhibit 142.

22
23 --- EXHIBIT NO. 142:

Submission of the
Association of Chartered
Physiotherapists of
Alberta.

24
25
26 MR. JARMAN: Mr. Chairman, for your
27 information I am Mr. W. L. Jarman, past president of the
28 Association of Chartered Physiotherapists of Alberta and
29 presently information officer. On my left I would like
30



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MR. ROBER: I think that is right.

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point, thank you.

THE CHAIRMAN: Thank you, Mr. Rober.

Your brief is clear, you state your position clearly and

frankly, and it will have our consideration.

of the

MR. W. L. JARMAN

THE SECRETARY: This will be exhibit 1A2.

EXHIBIT NO. 1A2:

Submission of the
Association of Chartered
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information I am Mr. W. L. Jarman, past president of the

Association of Chartered Physiotherapists of Alberta and

presently information officer. On my left I would like



1 to introduce to you Miss Nancy Randall, Assistant
2 Professor and Lecturer at the School of Physiotherapy at
3 the University of Alberta, Edmonton.

4 The Association of Chartered Physio-
5 therapists of Alberta (incorporated 1955) in its
6 summary of the contents of its brief to the Royal
7 Commission on Health Services wishes to emphasise the
8 following.

9 (a) The Association will do all in its power to
10 maintain as high an ethical and professional
11 standard of Physiotherapy in this Province as
12 is possible, at the same time maintaining the
13 close relationships that already exist with the
14 Medical Profession.

15 (b) The Association will give whatever assistance
16 it can in promoting vocations to Physiotherapy,
17 in helping to overcome the shortage of qualified
18 teachers and in promoting research.

19 (c) The Association is anxious to see expansion of
20 present services, both institutional and private,
21 especially out-patient facilities. Such services
22 should be included in presently existing medical
23 insurance plans.

24 (d) The Canadian Physiotherapy Association will be
25 presenting a full brief to the Royal Commission
26 at a later date this year.

27 THE CHAIRMAN: Have you had any word
28 as to when that brief will be presented?

29 MR. JARMAN: I think it is in May.

30 THE CHAIRMAN: In Toronto?



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as to when that brief will be presented?

MR. CHAIRMAN: I think it is in May.

THE CHAIRMAN: In Toronto?



1 MR. JARMAN: In Ottawa.

2 THE CHAIRMAN: Ottawa is in March.

3 MR. JARMAN: Then it may be May in
4 Toronto.

5 THE CHAIRMAN: Your distribution
6 throughout the province, how is it in terms of being
7 generally satisfactory, availability of physiotherapy
8 throughout the province?

9 MR. JARMAN: I think the shortage is
10 reasonably uniform throughout the province. Most hospitals,
11 institutions and so on employ physiotherapists and are
12 experiencing difficulty in obtaining staff, and I think
13 it is fairly uniform throughout the province. The newer
14 places further north of here may experience difficulty
15 in obtaining sufficient staff possibly due to the fact
16 that these places are somewhat unexplored in our
17 particular field.

18 THE CHAIRMAN: I see you graduated
19 twenty-eight from school in 1961. Is that pretty well
20 your full complement, Miss Randall?

21 MISS RANDALL: Well, our maximum for
22 registration at that time was thirty, thirty-three
23 actually registered at the beginning, and twenty-eight
24 made it all the way through.

25 THE CHAIRMAN: That is a pretty good
26 record. What about your second year and your third year,
27 would it go on pretty well almost one hundred per cent
28 capacity?

29 MISS RANDALL: Our present capacity
30 is forty. We have twenty in the second year and nineteen



MR. JARMAN: In Ottawa.

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1 in the last year.

2 THE CHAIRMAN: What about recruitment?

3 Are more offering than you can place or is it the other
4 way around?

5 MISS RANDALL: Not at the present time
6 with the new schools in British Columbia and Manitoba,
7 two outside recruiting areas are gone and we have to
8 recruit more in the Alberta area than we did before.

9 THE CHAIRMAN: What is the situation
10 as far as recruitment is concerned? I suppose you have
11 to have university entrance to begin with?

12 MISS RANDALL: Yes.

13 THE CHAIRMAN: You say you are able
14 to recruit and produce sufficient therapists for the
15 needs of Alberta?

16 MISS RANDALL: We hope to be able to.

17 THE CHAIRMAN: You graduated one
18 hundred and fifteen students from this school since 1954,
19 your first class ending in 1956. You have now working
20 seventy-eight. Thirty-seven are not working. What
21 happened to those thirty-seven, did they leave the
22 province or what?

23 MISS RANDALL: Most of the thirty-
24 seven got married.

25 THE CHAIRMAN: In that category, are
26 you like the nursing profession that you are able to
27 eventually draw upon married personnel after a few years,
28 after a certain number of years?

29 MISS RANDALL: Some have already come
30 back.



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MISS RANDALL: Some have already come



1 THE CHAIRMAN: Come back into the
2 profession at a later date?

3 MISS RANDALL: Yes.

4 THE CHAIRMAN: That will, as the number
5 of your graduates go on, that will make itself felt?

6 MISS RANDALL: We hope so, yes, sir.

7 THE CHAIRMAN: Thank you, very much,
8 Mr. Jarman and Miss Randall. This gives us quite a clear
9 picture of the situation in Alberta.

10 The next submission is from the Canadian
11 Public Health Association, Alberta Division. Is Dr.
12 Barrett here?

13 THE SECRETARY: That will be exhibit
14 143, sir.

15
16 --- EXHIBIT NO. 143: Submission of the Can-
17 adian Public Health
18 Association, (Alberta
19 Division)

20 SUBMISSION
21 OF THE
22 CANADIAN PUBLIC HEALTH ASSOCIATION
23 (ALBERTA DIVISION)

24 APPEARANCES:

25 DR. K. BARRETT
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27
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Jarman

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THE SECRETARY: That will be exhibit

EXHIBIT NO. 143: Submission of the Canadian Public Health Association (Alberta Division)

SUBMISSION

OF THE

CANADIAN PUBLIC HEALTH ASSOCIATION

ALBERTA DIVISION

APPEALANCES:

DR. L. BARNETT



1 DR. BARRETT: This brief is presented
2 by the Canadian Public Health Association (Alberta
3 Division), representing the views of approximately 300
4 members. This Association represents Medical Health
5 Officers, Dental Officers, Laboratory personnel, Public
6 Health Nurses, Occupational Health Nurses, Public Health
7 Inspectors and various auxiliary personnel. This
8 organization is primarily concerned with the practice of
9 Public Health and Preventive Medicine and provides
10 services to almost 100% of the population of Alberta.

11 We respectfully submit that:

- 12 1. With the increasing demand for hospital
13 services and the ever-increasing costs of medical
14 treatment, we suggest that more emphasis should be
15 placed on preventive medicine and rehabilitation.
- 16 2. Whereas the majority of Public Health
17 workers agree with the local Board system of
18 administration, ~~we, that is we as a board,~~ feel that
19 closer association and liaison with the Provincial
20 Department of Public Health would do much to
21 further the cause of Public Health in the Province
22 of Alberta. Members of local Boards of Health are
23 predominantly lay-people who are not conversant
24 with health matters. We recommend that the powers
25 of local Boards be curtailed in medical matters and
26 also that all hiring and firing of staff members
27 should be the prerogative of the Medical Director
28 in conjunction with the Deputy Minister of Health.
29 The dismissal of the Medical Director should only
30 be on the written instructions of the Deputy



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should be the prerogative of the Medical Director
in conjunction with the Deputy Minister of Health.
The duties of the Medical Director should only
be on the written instructions of the Deputy



1 Minister of Health.

2 3. In view of the fact that some local Boards
3 of Health are reluctant to allow their personnel to
4 take Post-Graduate training, we think the Department
5 of Public Health and the local Boards should
6 combine to encourage and facilitate further Post-
7 Graduate training and education for their staff.
8 This would ensure that Public Health personnel is
9 familiar with the continuous changes that are
10 taking place in the field of medicine.

11 4. Due to the autonomy of the local Health
12 Boards, there appears to be a difference in the
13 quantity and quality of Public Health Services in
14 Alberta. Therefore, it is suggested that the
15 Department of Public Health make every effort to
16 standardize the services and salaries of Public
17 Health workers. It is felt that these salaries
18 should bear a relation to those obtained in other
19 medical fields.

20 5. It is our opinion that there is room for
21 improved co-ordination of existing health services
22 within the Province, particularly Mental and General
23 Hospital services in relation to Public Health
24 services.

25 6. There should be an expansion of existing
26 home nursing services. We believe this service,
27 in rural areas, should be under the administrative
28 control of local Health services. Expansion of
29 home nursing services - especially for chronic
30 patients - would free hospital beds for acute cases.



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In view of the fact that some local Boards

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control of local Health services. Expansion of

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patients - would free hospital beds for acute cases.



7. The Indian and Metis population should receive the same Public Health services as are afforded to the rest of the community.

8. To have better understanding and co-operation, in the fields of Public Health and hospital administration, we recommend that the key executive personnel in the Provincial Department of Public Health should be qualified Physicians.

9. There should be closer co-operation between the Faculty of Public Health in the University of Alberta and the Public Health workers in the field.

10. Since accidents and violence are chief causes of death in the age group 1 - 39 years, and since this is a problem which is increasing yearly, we recommend that not only death but all serious injuries due to accidents, violence and poisoning should be notifiable so that ways and means can be found to help prevent such occurrences.

11. We recommend stricter and quicker notification of communicable diseases so that control measures can be taken at once to prevent the spread of such diseases.

THE CHAIRMAN: Thank you, Dr. Barrett.

COMMISSIONER VAN WART: Mr. Chairman, I would like to make some inquiries regarding the local boards of health. First of all, you speak of a medical director. Now, the medical director, is he a member of the Department of Health or is he a local appointee?

THE CHAIRMAN: You may remain seated,



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THE CHAIRMAN: Thank you, Dr. Barrett.

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director. Now, the medical director, is he a member of
the Department of Health or is he a local appointee?

THE CHAIRMAN: You may remain seated.



1 Dr. Barrett, if you wish.

2 DR. BARRETT: The answer to that is
3 the medical director is the doctor who is employed by
4 the local boards to act on their behalf.

5 COMMISSIONER VAN WART: How is the
6 local board appointed?

7 DR. BARRETT: The local board is
8 constituted when the local people request the minister
9 to set up a health unit. They come together and decide
10 that they will create these communities. They will
11 contribute, in the boundaries defined by the Minister
12 of Health to be set up as a unit, each municipality in
13 this unit contributes financially and each municipality
14 appoints a member of council to be on the board of this
15 health unit, and the local board is predominately lay
16 people. They hire a staff. They hire a medical director
17 who is a doctor and then nurses, health inspectors,
18 and dental technicians.

19 COMMISSIONER VAN WART: Who is the
20 chairman of this board?

21 DR. BARRETT: When the various
22 appointed councillors meet to form a board of health
23 they elect from one of their members one person who
24 acts as chairman.

25 COMMISSIONER VAN WART: Is it
26 necessary by law that a member of the medical profession
27 be on the board?

28 DR. BARRETT: There is no stipulation
29 there, sir. A medical practitioner can be on the board.
30 It is not usual.



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1 COMMISSIONER VAN WART: In practice it
2 is not usual?

3 DR. BARRETT: In practice it is rare,
4 I would say.

5 COMMISSIONER VAN WART: Rare. They
6 appoint a medical director from their community?

7 DR. BARRETT: They advertise for a
8 doctor and it is very rare that the doctor is from the
9 community. These people are public health trained
10 doctors, and they are usually from outside parts.

11 COMMISSIONER VAN WART: He is respon-
12 sible to the local board and not to the Department of
13 Health?

14 DR. BARRETT: They are hired by the
15 local board. They are fired by the local board, and the
16 salary comes jointly from the Department and from the
17 municipality.

18 COMMISSIONER VAN WART: Does that
19 local board receive direction in public health matters
20 from the Department of Health?

21 DR. BARRETT: Yes, receives advice
22 on matters from the Department.

23 COMMISSIONER VAN WART: They are not
24 obliged to take that advice?

25 DR. BARRETT: No, they can take it or
26 they need not take it. Of course, there is a Health Unit
27 Act which lays down very broadly the procedures to be
28 followed.

29 COMMISSIONER VAN WART: The local board
30 is then responsible to the municipal district that has



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1 been set up?

2 DR. BARRETT: Yes.

3 COMMISSIONER VAN WART: How long is
4 their term of office, as a rule?

5 DR. BARRETT: I believe these appoint-
6 ments should be made annually.

7 COMMISSIONER VAN WART: Annually?

8 DR. BARRETT: I believe so. I believe
9 in practice what happens is that when somebody is on
10 one of these boards he stays on for a prolonged period.
11 I do believe there is something that says he should be
12 re-elected every year.

13 COMMISSIONER VAN WART: It is possible
14 that the whole board may turn over annually, that is,
15 have a new board every year. It is possible?

16 DR. BARRETT: I am not sure of that
17 question. I would like Dr. Smith to answer it.

18 DR. E. S. O. SMITH: A board member
19 holds his appointment on the board at the pleasure of
20 the council to which he belongs.

21 COMMISSIONER VAN WART: It is possible
22 the board can change?

23 DR. E. S. O. SMITH: It is possible,
24 yes.

25 COMMISSIONER VAN WART: There is no
26 continuity guarantee anywhere?

27 DR. E. S. O. SMITH: No guarantee of
28 continuity, and each board member must be a councillor.
29 He holds his seat on the council and proceeds to be a
30 member of the board.

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member of the board.



1 COMMISSIONER GIRARD: My question is
2 on the first page, paragraph 3, where it states:

3 In view of the fact that some local
4 Boards of Health are reluctant to allow their
5 personnel to take Post-Graduate training."

6 Would you please tell me, if you know, why the boards
7 are reluctant to let their personnel take post-graduate
8 training.

9 It was stated here yesterday that only
10 about half of the public health nurses are qualified as
11 public health nurses. I suppose this would apply to
12 other public health officials?

13 DR. BARRETT: Well, that is a rather
14 difficult question to answer; why they chose to behave
15 this way.

16 COMMISSIONER GIRARD: Is it a question
17 of money; or not having enough personnel, so they can't
18 let some away for training?

19 DR. BARRETT: I would say it is
20 predominately a question of cost.

21 COMMISSIONER GIRARD: There are
22 scholarships. Are there scholarships?

23 DR. BARRETT: There are bursaries
24 provided by the provincial government.

25 COMMISSIONER GIRARD: Do you know if
26 these bursaries are sufficient? Maybe there is a
27 reluctance on the part of the members themselves to
28 avail themselves of these bursaries if the bursaries
29 are not sufficient to take the post-graduate course.
30 There are some public health nurses here who might answer.



COMMISSIONER CHAND: My question is

on the first page, paragraph 3, where it states:

In view of the fact that some local

Boards of Health are reluctant to allow their

personnel to take post-graduate training."

Would you please tell me, if you know, why the boards

are reluctant to let their personnel take post-graduate

It was stated here yesterday that only

about half of the public health nurses are qualified as

public health nurses. I suppose this would apply to

other public health officials?

DR. BARNETT: Well, that is a rather

difficult question to answer; why they chose to behave

this way.

COMMISSIONER CHAND: Is it a question

of money, or not having enough personnel, so they can't

let some away for training?

DR. BARNETT: I would say it is

predominately a question of cost.

COMMISSIONER CHAND: There are

DR. BARNETT: There are nurses

provided by the provincial government.

COMMISSIONER CHAND: Do you know if

these hospitals are sufficient? Maybe there is a

reluctancy on the part of the members themselves to

avail themselves of these hospitals if the hospitals

are not sufficient to take the post-graduate course.

There are some public health nurses here who might answer.



1 DR. BARRETT: These bursaries are
2 for prolonged training, perhaps a one year course. What
3 we have in mind here, was going to conventions, and
4 short courses, perhaps a month or two months training
5 at a centre, perhaps in the States or in Eastern Canada.

6 COMMISSIONER GIRARD: You mention
7 post-graduate training. You mention being reluctant to
8 take post-graduate training. I suppose conventions
9 and things like that are educational. I shouldn't say
10 I suppose. I know they are. But I can see maybe the
11 Department not being able to let too many people go
12 to conventions at one time.

13 Here you talk about being reluctant
14 to let them take post-graduate training. Why bring
15 this up? Because I feel that maybe twenty out of the
16 thirty briefs we have received, have mentioned home
17 care as something for the future.

18 If we are going to look into home care
19 in the future, we had better prepare our public health
20 nurses now; because public health nurses will be
21 in great demand for home care services. If we don't
22 start preparing public health nurses now, I don't know
23 how we are going to get all these home care plans going,
24 and home care seems to be one of the things that every-
25 one wants to see in the future, as one of the means
26 of decongesting hospitals, I would say. That is why
27 I bring this up.

28 DR. BARRETT: When we mentioned
29 post-graduate training, we had in mind, training in
30 administration, and that type of training.



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1 As far as home care is concerned, we
2 do not feel that public health personnel should actively
3 engage in this except administratively in rural areas.

4 COMMISSIONER GIRARD: Excuse me.

5 When you say public health personnel, you mean public
6 health personnel working for the government. The V.O.N.
7 are public health nurses, and can be classified as
8 public health personnel. She is not an official of the
9 Public Health Department, but she can be classified as
10 public health personnel.

11 DR. BARRETT: We feel that home
12 nursing usually would be better undertaken by V.O.N.

13 COMMISSIONER GIRARD: By voluntary
14 agencies or V.O.N. or others?

15 DR. BARRETT: Yes, rather than
16 public health nurses.

17 COMMISSIONER GIRARD: The fact remains,
18 do you not agree, that public health nurses are public
19 health personnel, and should be qualified?

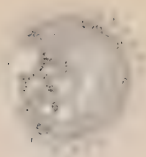
20 DR. BARRETT: Yes, I do.

21 COMMISSIONER GIRARD: And this
22 reluctance of the government to have trained personnel
23 qualified in public health ----

24 THE CHAIRMAN: Is it the Department
25 or the health unit?

26 DR. BARRETT: The local boards of
27 health.

28 COMMISSIONER GIRARD: I was thinking
29 of the department on a municipal basis, local boards of
30 health.



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health.



1 DR. BARRETT: We feel that the local
2 board and the Department should get together and generally
3 encourage and finance some of this training.

4 COMMISSIONER GIRARD: I feel the same
5 way, thank you very much.

6 THE CHAIRMAN: Dr. Baltzan?

7 COMMISSIONER BALTZAN: All of my
8 questions have already been put and I am left speechless.
9 Thank you very much.

10 COMMISSIONER GIRARD: Excuse me.

11 I have another question, No. 9:

12 "There should be closer co-operation
13 between the Faculty of Public Health
14 in the University of Alberta and the
15 Public Health workers in the field."

16 I agree with you. What form should this closer co-
17 operation take, in your view?

18 DR. BARRETT: Well, I feel here that
19 the workers in the university should meet and lecture to
20 and take a greater interest in the workers in the field.
21 I feel that they should, as I say, take a greater
22 interest in what goes on in the field.

23 COMMISSIONER GIRARD: You mean also
24 that they could be very helpful in service education for
25 the personnel in the field?

26 DR. BARRETT: Yes, by way of lectures
27 and meetings.

28 COMMISSIONER GIRARD: And this co-
29 operation is not as you would like it now?

30 DR. BARRETT: I would like to see it



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COMMISSIONER GIRARD: And this co-

operation is not as you would like it now?

DR. BARRITT: I would like to see it



1 improved.

2 COMMISSIONER GIRARD: Well, for my
3 own personal information, would you also mention what are
4 the communicable diseases -- the most prevalent ones --
5 that demand notification. I understand that there are
6 many of them that are not notifiable any more?

7 DR. BARRETT: Yes!

8 COMMISSIONER GIRARD: You suggest that
9 they should be stricter and quicker on the patients?

10 DR. BARRETT: Now, I had in mind there
11 infectious hepatitis, rubella and measles. These are
12 the main ones. We have pretty rapid notification of
13 polio and typhoid, but as far as the others are concerned,
14 they are the ones we would like more rapid notification
15 on.

16 COMMISSIONER McCUTCHEON: Are they all
17 reportable?

18 DR. BARRETT: Yes.

19 COMMISSIONER GIRARD: Thank you.

20 COMMISSIONER FIRESTONE: Dr. Barrett,
21 in recommendation one, the suggestion is made that more
22 emphasize should be placed on preventive medicine and
23 rehabilitation, and the reason for this recommendation
24 is given:

25 "The increasing demand for hospital
26 services and the ever-increasing costs
27 of medical treatment."

28 Do I understand from the way the
29 recommendation is worded that you are in favour of ex-
30 tension of preventive medicine and rehabilitation mainly



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COMMISSIONER MONTGOMERY: Are they all reportable? DR. BARNETT: Yes.

in recommendation one, the suggestion is made that more emphasis should be placed on preventive medicine and rehabilitation, and the reason for this recommendation is that the increasing demand for hospital services and the ever-increasing costs of medical treatment."

Do I understand from the way the recommendation is worded that you are in favour of extension of preventive medicine and rehabilitation mainly



1 to achieve economies in hospital care and medical care;
2 or, would you prefer to broaden this recommendation in
3 saying that you are in favour of extending medical care
4 and hospital care and rehabilitation as an extension of
5 services to improve the health care generally?

6 DR. BARRETT: Yes, sir. I would like
7 to extend preventive medicine and rehabilitation to
8 improve the health of the community generally, but to
9 bring it down to a practical point, it would relieve the
10 over-congestion of our acute hospital beds.

11 COMMISSIONER FIRESTONE: So, it is both
12 factors which are behind the recommendation?

13 DR. BARRETT: Yes, sir.

14 COMMISSIONER FIRESTONE: Thank you.
15 Dr. Barrett, in recommendation No. 2, you recommend the
16 powers of local boards be curtailed in medical matters,
17 and you spell out what some of those curtailments may be.

18 Would you not say that this is largely
19 a matter within provincial jurisdiction, and if the
20 answer is yes, have you made any suggestions or has your
21 association made any suggestions to this end to the
22 provincial government?

23 DR. BARRETT: The powers of the local
24 board are completely -- I would not say completely but
25 they are separate from the provincial department. The
26 boards have a very high degree of local autonomy. The
27 Department of Public Health acts in an advisory and
28 supervisory capacity in the policies and things like
29 that; staff matters. Most of the running is up to the
30 local board of health.

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28 saying that you are in favour of extending medical care

29 or, would you prefer to broaden this recommendation in

30 to achieve economies in hospital care and medical care;



1 COMMISSIONER FIRESTONE: How are these
2 boards established in the first place? Under what
3 authority?

4 DR. BARRETT: Under the Health Unit
5 Act. A group of municipalities request the Minister to
6 group them to find their boundaries, and set them up
7 as a health unit. Then, each municipality appoints a
8 council member and those members come together and form
9 a board, and from themselves they chose one of their
10 people to be chairman of the board, and that constitutes
11 the board.

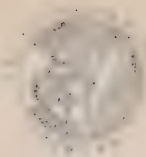
12 COMMISSIONER FIRESTONE: Now, how could
13 this objective which you have described in paragraph 2
14 be achieved? Could it be achieved by an amendment to
15 the Health Unit Act?

16 DR. BARRETT: Yes, sir, I believe it
17 would require an amendment to the Health Unit Act.

18 COMMISSIONER FIRESTONE: In other
19 words, this is largely a provincial matter which a Royal
20 Commission like this that is concerned with matters that
21 may involve some action that the federal government
22 might take would really not become involved in this
23 particular recommendation; am I right? Or, is there
24 anything the federal government should do?

25 DR. BARRETT: It would need a change
26 in legislation at the provincial government, which the
27 Commission may or may not decide to recommend. That is
28 how we felt.

29 COMMISSIONER FIRESTONE: Well now, as
30 you appreciate, sir, this Royal Commission has been



COMMISSIONER FLEMING: How are these

boards established in the first place? Under what

authority?

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You appreciate, sir, this Royal Commission has been



1 established -- the federal government is concerned with
2 matters that are within the jurisdiction of the federal
3 government, and therefore, concern federal affairs.

4 If there is a specific local condition
5 which falls exclusively, as you explained to us, under
6 provincial jurisdiction, I presume you will want to make
7 representations of this limited affair to the provincial
8 government?

9 DR. BARRETT: Yes.

10 COMMISSIONER FIRESTONE: You have not
11 done so as yet?

12 DR. BARRETT: No, sir, no.

13 COMMISSIONER FIRESTONE: I see. Thank
14 you.

15 In paragraph 3, you suggest that the
16 Department of Public Health and local boards should
17 combine to encourage and facilitate further post-graduate
18 training and education.

19 Have you any specific suggestions as to
20 how this encouragement and facilitating could be achieved?
21 For example, you had in mind more generous bursaries?

22 DR. BARRETT: Well, I would feel
23 more bursaries --

24 COMMISSIONER FIRESTONE: More bursaries,
25 or more generous bursaries, or both?

26 DR. BARRETT: I feel more bursaries
27 being made available.

28 COMMISSIONER FIRESTONE: And are you
29 satisfied that the bursaries that are now available are
30 adequate in terms of amount?

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COMMISSIONER FIRESTONE: And are you

satisfied that the pressures that are now available are

adequate in terms of amount?



1 DR. BARRETT: I am not familiar with
2 just how good the bursaries are, but I have not heard
3 complaints about them. It is a question of more bursaries
4 being made available. That is the point.

5 COMMISSIONER FIRESTONE: And these are
6 bursaries provided by the provincial government?

7 DR. BARRETT: Yes, and the local boards
8 can authorize one of its members to go for further
9 training.

10 COMMISSIONER FIRESTONE: Now, if the
11 funds available for such bursaries are, in the opinion
12 of the local boards and the provincial government,
13 limited, what would your recommendation be: that the
14 federal government make a contribution to such bursaries
15 to extend their number, and if the amount is found to be
16 inadequate, the amount as well?

17 DR. BARRETT: Yes, sir, I would.

18 COMMISSIONER FIRESTONE: In paragraph
19 4 of your recommendations, you refer to a difference in
20 the quantity and quality of public health services in
21 Alberta.

22 Could you indicate to the Commission what
23 are some of the differences in quality of public health
24 services in Alberta?

25 DR. BARRETT: Yes, sir. Each medical
26 director proposes to his board a certain policy and
27 certain services that he would like them to provide for
28 the public.

29 Now, some boards will go along with
30 suggestions; some boards feel that they should not.



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 complaints about them. It is a question of more businesses
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COMMISSIONER WIRESTONE: And these are
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1 field of preventive dentistry, I would like to see more
2 done.

3 COMMISSIONER FIRESTONE: Would you say
4 there are a number of regions where the Public Health
5 Service in the Province of Alberta falls below the
6 standard which the Department of Health has set, and
7 which your association has endorsed?

8 DR. BARRETT: No, sir, I would not.

9 COMMISSIONER FIRESTONE: Have you made
10 a survey?

11 DR. BARRETT: No, sir.

12 COMMISSIONER FIRESTONE: Therefore,
13 your answer of no was based on the fact that you really
14 have not looked into this question as to how many of the
15 health regions of the province of Alberta meet the
16 standard, and how many do not?

17 DR. BARRETT: Well, sir, I will tell
18 you what I base my answer on. In two and a half years
19 experience with other medical officers, and reading
20 their quarterly reports for each unit and annual reports,
21 I have a good idea of what services are being provided,
22 and what is being done.

23 COMMISSIONER FIRESTONE: And you would
24 feel, on the basis of your personal observations, that
25 the health standards -- that the standards used in these
26 various health regions come up to the standards which
27 the Department of Health has set up as minimum, desirable
28 standards, and which you endorse?

29 DR. BARRETT: I would say so,
30 generally speaking, that in the field of preventive

field of preventive dentistry, I would like to see more done.

There are a number of regions where the Public Health Service in the Province of Alberta falls below the standard which the Department of Health has set, and which your association has endorsed?

COMMISSIONER FLETCHER: Have you made

a survey?

Your answer of no was based on the fact that you really have not looked into this question as to how many of the health regions of the province of Alberta meet the standard, and how many do not?

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DR. FLETCHER: I would say so.

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1 Now, some boards, for example, will have
2 a full-time dental officer and staff and provide good
3 preventive dental treatment. Others do not have dental
4 services; others will have final year students painting
5 fluorides on teeth during summer holidays.

6 So, there is quite a difference in that
7 type of service.

8 COMMISSIONER FIRESTONE: Has your
9 association developed minimum standards which you con-
10 sider would be required to achieve a reasonable service
11 in public health?

12 DR. BARRETT: Well, sir, there are
13 services advocated by the Department of Public Health,
14 and these services are good, and any of those services
15 a board wishes to provide for its community they may do
16 so, and use local funds, plus provincial grants to
17 provide them.

18 Services over and above those must be
19 provided for exclusively by money derived from the local
20 contributing parties.

21 COMMISSIONER FIRESTONE: Would you
22 say, sir, that your own association endorses the standards
23 which have been established by the Department of Health?

24 DR. BARRETT: Yes, sir, I would.

25 COMMISSIONER FIRESTONE: Now, could
26 you then, perhaps, explain to us, sir, whether there are
27 a number of areas in the province of Alberta which do not
28 provide services up to what you consider and the
29 Department of Health considers a minimum standard?

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DR. BARNETT: I would say in the



1 dentistry I would feel that much more could be done.

2 COMMISSIONER FIRESTONE: Now, outside
3 the field of preventive dentistry, which is a specialized
4 field, and we have heard a good deal about it, would you
5 feel that by and large these reasonable minimum standards
6 you are talking about are, in fact, in existence?

7 DR. BARRETT: I would, sir, yes.

8 COMMISSIONER FIRESTONE: Well, if this
9 is the case, I wish you would explain to me the
10 recommendation in paragraph 4. As I understand it from
11 this recommendation, it is that because there exists
12 such a difference in quality you would like this quality
13 to be brought up to what is considered a minimum
14 desirable standard? If everything is fine, well, perhaps
15 there is no need to improve the quality?

16 DR. BARRETT: Well, some health units
17 go above minimum standards, and that minimum standard,
18 now, I feel should get another look, and I feel that we
19 should try and bring all units up to above that minimum
20 standard level, and a lot of units are above minimum
21 standards.

22 COMMISSIONER FIRESTONE: If I under-
23 stand you correctly, there is a minimum standard in
24 existence, but you would feel this minimum standard is
25 too low, and you would like to see it raised?

26 DR. BARRETT: Yes, sir. That is right.

27 COMMISSIONER BALTZAN: At this point,
28 do you, sir, as a public health officer, relish the idea,
29 the principle of gearing yourself, or setting your sights
30 to that of minimal standards, whatever that thing means?



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DR. LARRETT: Yes, sir. That is right.

COMMISSIONER WHEATON: At this point,

do you, sir, as a public health officer, believe the principle of leaving yourself, or setting your sights to that of minimal standards, whatever that thing means?



1 DR. BARRETT: No, sir, I would like to
2 go over beyond those minimum standards.

3 COMMISSIONER BALTZAN: That is just
4 what I wanted to hear from you.

5 I am sorry for the interruption.

6 COMMISSIONER FIRESTONE: Not at all,
7 Dr. Baltzan.

8 You would like to see those health
9 standards raised?

10 DR. BARRETT: Yes.

11 COMMISSIONER FIRESTONE: Could you give
12 us a definition as to what kind of health standards you
13 have in mind from what are presently considered minimum
14 standards to a higher standard, which you still consider
15 realistic in practice? This may be a difficult question,
16 and please feel free to say you wish to give further
17 consideration to the question, and give us your answer
18 at a later stage. You realize if we are to make
19 recommendations, we must have an understanding of the
20 kind of standard you set as a desirable target.

21 DR. BARRETT: Yes, sir. Well, without
22 giving it too much consideration, I would like to say
23 that accident prevention, for example, would be one field;
24 prevention of cancer; anti-smoking campaigns would be
25 quite a help, too.

26 Also, I would like to see progress
27 instituted that would cut down on the incidence of heart
28 disease. There are many fields which we could go into,
29 if we had more personnel.

30 COMMISSIONER FIRESTONE: Would you



DR. BARRETT: No, sir, I would like to

to cover beyond those minimum standards.

COMMISSIONER BALTAN: That is just

what I wanted to hear from you.

I am sorry for the interruption.

Dr. Barrett.

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DR. BARRETT: Yes.

COMMISSIONER FINESTONE: Could you give

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COMMISSIONER FINESTONE: Would you



1 know, for example, whether the National Association --
2 the National Public Health Association -- might be coming
3 forward to this Royal Commission with a set of
4 recommendations of what would be the desirable standards?

5 DR. PARRETT: Yes, sir. We fully
6 endorse the National body's recommendation, and we did
7 submit a brief to them.

8 COMMISSIONER FIRESTONE: You have an
9 advantage over us; we have not yet seen the forthcoming
10 recommendation. What I would hope is that you may
11 perhaps pass on to them that this Commission is interested
12 in the sort of standards you were talking about, and
13 perhaps we can receive from the National organization
14 some suggestion as to what such standards should include?

15 DR. BARRETT: Yes. They have our
16 recommendations.

17 COMMISSIONER FIRESTONE: Have your
18 recommendations included proposals for national improved
19 standards in the field of public health services?

20 DR. BARRETT: Yes, sir. We did not
21 spell it out in detail.

22 COMMISSIONER FIRESTONE: Would it be
23 possible for you to pass on to your National organization
24 the questions addressed to you. We would be interested
25 if their organization has some views on the subject to
26 put forward to us sufficient details so we can understand
27 what is involved in raising the standards of public health
28 service in Canada?

29 DR. BARRETT: Yes, sir. I would like
30 to do that.



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DR. BARRETT: Yes, sir. I would like



1 COMMISSIONER FIRESTONE: Thank you very
2 much. You have been most helpful.

3 May I come to one question which is not
4 covered in your submission, and with the Chairman's
5 permission I would like to address this question to you
6 in your capacity as a medical health officer for the
7 city of Calgary.

8 If somebody takes seriously ill on a
9 Saturday afternoon, and he calls his physician, and the
10 physician is not at home, what does this person do if he
11 cannot find his family physician?

12 DR. BARRETT: Well, the tendency now-
13 adays is to have groups of doctors rather than doctors in
14 solo practice. And, usually, they can get a hold of a
15 doctor in the same group.

16 If a doctor in solo practice decides to
17 take an afternoon off, he delegates his duties to somebody
18 else. He asks a colleague to sit in for him and take his
19 calls.

20 THE CHAIRMAN: Is there in existence
21 here a sort of telephone answering service whereby a
22 call is transferred to a central registry?

23 DR. BARRETT: Yes, sir, there are
24 several in Calgary.

25 COMMISSIONER FIRESTONE: Do you in your
26 department get calls from people who cannot find any
27 physician to look after them for one reason or another?

28 DR. BARRETT: I have never had such a
29 request in Calgary. I have had calls to my own home in
30 relation to innocations or vaccinations which were



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1 performed at our clinic, and I have given advice that
2 way. But since I have been in Calgary, I have not been
3 requested to see an acutely ill person for any reason.
4 COMMISSIONER FIRESTONE: There are
5 adequate provisions, however, for any one to get medical
6 care and attention quickly, either from his own physician
7 or through some group arrangement?

8 DR. BARRETT: Yes, sir, I would say so.

9 COMMISSIONER FIRESTONE: Thank you very
10 much.

11 MR. HOMAN: Mr. Chairman, is it in
12 order for a point of information to come from the gallery?

13 THE CHAIRMAN: Yes, if it is relevant.

14 MR. HOMAN: Thank you kindly. My
15 name is Homan, and I am the Assistant Deputy Minister of
16 Health. My point of information would be to clarify, if
17 I possibly may, the difference in the legislation that
18 you have been discussing between the executive and the
19 administrative, and I am afraid that perhaps a point was
20 not too clearly made.

21 THE CHAIRMAN: Yes. We will be happy
22 to hear from you.

23 MR. HOMAN: I am not degrading what
24 Dr. Barrett was saying in any way. I am only wanting to
25 add to the information for clarity.

26 First and foremost, all municipal
27 legislation be it the City Act, or the Town and Village
28 Act, or the County Act -- whatever it may be -- provides
29 a requisite for a local board of health as an adjunct
30 to the provincial Board of Health, under the Public Health



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1 Act.

2 Now, that is your executive or legislative
3 requirement of local provincial government for public
4 health services. Then, the Health Unit Act, as mentioned,
5 becomes an administrative function of putting local
6 health services into operation. That Act requires the
7 local board of health to carry out the provisions of the
8 Public Health Act and its regulations.

9 Failing to do this, the provincial board
10 may step in for the local board and exercise those
11 authorities. This is true that they can be categorized
12 as minimal, but it is for the prevention and spread of
13 communicable diseases and the many facets of public health.
14 To this end, then, the province assess on a per capita
15 basis in relation to the local health area. There will
16 be so many dollars per capita to that local board.

17 There is another requisite that the local
18 board, through its local authorities, levy a supplementary
19 tax to arrive at over-all basic budgets for the programme.

20 THE CHAIRMAN: Is it a similar amount?

21 MR. HOMAN: No, the ratio under the
22 statute is two-thirds to one-third -- sixty-forty.
23 Sixty, the province; and forty, the local.

24 THE CHAIRMAN: Yes, thank you.

25 MR. HOMAN: Then, it goes on to say at
26 the local level the board is free to go on as high as it
27 so elects and wishes to do.

28 Now, this, then, will bring about the
29 comparable factor which Dr. Barrett spoke of between the
30 local authority in the adjoining metropolitan areas, the



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local authority in the adjoining metropolitan areas, the



1 populated areas, or the better or well-to-do areas as
2 against the very remote, sparsely populated, and not so
3 well-to-do local authorities. But this alleged or so-
4 called minimum is maintained as an ideal or an objective
5 but it is not a ceiling. The local board may institute
6 and add any other facilities it so wishes. That was my
7 point, sir.

8 THE CHAIRMAN: Thank you very much, Mr.
9 Homan. Mr. Homan, that explanation was very much in
10 order and we are pleased to have it.

11 Dr. Barrett, have you anything further to
12 add?

13 DR. BARRETT: No, sir, I agree with all
14 he has said except that I do not recall any instance
15 where the provincial Board of Health has ever altered
16 what has been laid down by the local board of health.

17 THE CHAIRMAN: I suppose that must
18 mean there has not been conflict with what one has done
19 in terms of the other. Thank you very much, Dr. Barrett.

20 This is the last of the submissions of
21 which we had prior notice. Have you anything further,
22 Mr. Lafrance?

23 THE SECRETARY: I have received from
24 the Alcoholism Foundation of Alberta a letter dated
25 January 31, 1962 which they would like incorporated in
26 the record. This is signed by Mr. J. George Strachan.
27 I will give this to the court reporter and it will be
28 part of this record.

29

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well-to-do local authorities. But this alleged or so-called minimum is maintained as an ideal or an objective but it is not a ceiling. The local board may institute and add any other facilities it so wishes. That was my point, sir.

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" THE ALCOHOLISM FOUNDATION OF ALBERTA

9910-103rd Street,

Edmonton, Alberta,

January 31st, 1962.

Royal Commission on Health Services,

Post Box 1173,

Ottawa, Ontario.

Gentlemen: Re: Edmonton-Alberta Hearings.

For file with presentations.

The Alcoholism Foundation of Alberta is collaborating with other members of the Canadian Council on Alcoholism in a joint presentation to be made by the chairman, Mr. H. David Archibald. Since this is the case no comprehensive presentation will be made by this Foundation. This notice is therefore by way of recording our decision regarding the joint presentation of a brief and as a means of perhaps emphasizing one or two points of provincial interest and concern.

The Foundation is a non-profit, non-controversial, private agency, supported by provincial and municipal grants, and membership donations from associations, companies and individuals. It is the authorized representative body for the Province of Alberta in the field of alcoholism. The major portion of the Foundation's revenue is that received by provincial grant through the Department of Health.

The Foundation maintains broad programmes of treatment, rehabilitation, education and research. The goal of these programmes is the prevention of



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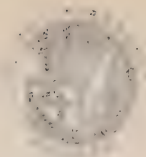
1 alcoholism. To better describe the activities of the
2 Foundation we are enclosing our last Annual Report and
3 an earlier study released as a Five-Year Review of
4 Activities. Other materials are available upon request.

5 The Foundation presently operates two
6 full-time centres in Edmonton and Calgary and an
7 Information and Referral Centre in Lethbridge with
8 additional services being provided throughout the province
9 by a visiting team of Foundation personnel.

10 It should be pointed out that the
11 Foundation was established as a committee appointed
12 through the College of Physicians and Surgeons and later
13 incorporated under the Societies Act with the agreed
14 decision on the part of the initial board and the
15 Provincial Government to establish this Foundation as
16 a private organization and as a quasi governmental body.
17 A special rehabilitative service is provided through the
18 Attorney-General's Department for the incarcerated
19 alcoholic.

20 The three points that we would emphasize
21 in this letter that we feel are particularly applicable
22 to the needs of the province are:

- 23 (1) The attraction, recruitment and training of
24 professional personnel to staff alcoholism
25 programmes -- particularly social workers,
26 psychologists, sociologists, doctors and nurses
27 -- is of high priority if we are to develop
28 adequate preventive concepts in this field.
29 We therefore, recommend that the Commission give
30 consideration to the provision of substantial



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1 sums for these purposes. In addition to funds
2 for training new personnel, provision should be
3 made for further development and training of
4 personnel presently engaged in work in alcoholism.

5 NOTE: The federal government has just employed two
6 fully trained treatment workers from this Foundation.

7 (2) A significant amount of time of Foundation
8 personnel is, and has been, devoted to working
9 with such federal groups and agencies as are a
10 part of those services extended in this province.
11 These agencies are the responsibility of the
12 federal government. Among these are the Armed
13 Forces, Indians, Postal Employees, D.V.A.,
14 Supervisory Personnel at the Prince Albert
15 Penitentiary, National Employment Service and
16 Civil Service Employees, and others. Support
17 of the continuance and expansion of such work,
18 we believe, should be shared in part at least by
19 the federal government.

20 Such work must be performed by the
21 Alcoholism Foundation of Alberta, if we are to
22 adequately and properly integrate a total approach
23 to problems of alcohol and particularly
24 alcoholism.

25 (3) We would particularly emphasize the need for
26 funds for both these special kinds of preventive
27 services and educational activities and for research.
28 In the past, the Alcoholism Foundation of Alberta
29 has submitted requests for such funds to the
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1 and provincial level and despite the value of
2 the studies for the entire field of alcoholism
3 and other health fields as well, such requests
4 have invariably been turned down at the federal
5 level. We suggest, therefore, that funds for
6 research in alcoholism be made both through the
7 proposed Canadian Foundation on Alcoholism and
8 the Federal Department of Health.

9 May I submit this endorsement to the
10 Canadian Council on Alcoholism brief. While we believe
11 the above points to be especially pertinent to Alberta,
12 and to other provincial programmes so engaged, we do
13 wholeheartedly agree with the full brief to be presented
14 by the Canadian Council on Alcoholism.

15 Respectfully submitted by

16 THE ALCOHOLISM FOUNDATION OF ALBERTA,
17 J. GEORGE STRACHAN."

18 THE CHAIRMAN: Is there any one else
19 present who has any submission to make to the Commission
20 before we wind up our hearings here in Edmonton?

21 DR. JOHNSTON: Mr. Chairman, I was with
22 Dr. Gogan this morning and in the course of our general
23 submission or statement, we recognize that you were
24 presumably rushed before lunch and I remember not including
25 some remarks about the provision of a home care plan.

26 THE CHAIRMAN: Would you come forward,
27 Dr. Johnston?

28 DR. JOHNSTON: Yes, sir. In the
29 submission given by Dr. Gogan this morning in relation
30 to the problems which we face in Calgary because of the



and provincial level and despite the value of the studies for the entire field of alcoholism and other health fields as well, such requests have invariably been turned down at the federal level. We suggest, therefore, that funds for research in alcoholism be made both through the proposed Canadian Foundation on Alcoholism and the Federal Department of Health.

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1 apparent rush no reference was made to the establishment
2 of a home care plan in the City of Calgary. This has
3 been uppermost in our minds, not only Dr. Gogan and my-
4 self, but others in the city. I would like to state that
5 in the presentation which we will forward by mail which
6 we were asked to do I would like to have that appended
7 if that can be done.

8 THE CHAIRMAN: It certainly can and it
9 will be most welcome.

10 DR. JOHNSTON: Thank you, we appreciate
11 that and your courtesy.

12 THE CHAIRMAN: Is there anyone else?
13 If there is no one we will declare the hearings here at
14 an end. As we conclude our hearings here I want to
15 express the thanks of the Commission to all who have
16 participated throughout the week. We have had a great
17 deal of information and help, and the briefs and
18 submissions which have come forward indicate that those
19 who prepared these briefs worked on them, took their
20 jobs very seriously and did a lot of work. Because of
21 that the briefs and submissions have been of real value.

22 We are grateful to the government of
23 Alberta for its co-operation for having placed these
24 facilities at our disposal and for having been so
25 co-operative in its appearance before the Commission in
26 making information available.

27 We have had a very pleasant week here in
28 this court room. I think it will be conceded we have
29 perhaps, disrupted the orderly course of things in this
30 corridor and I have no doubt we have added to Mr. Short's



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